TAHOE FOREST HOSPITAL DISTRICT

2016-09-22 Regular Meeting of the Board of Directors

Thursday, September 22, 2016

Tahoe Truckee Unified School District

11603 Donner Pass Rd, Truckee CA 96161

Meeting Book - 2016-09-22 Regular Meeting of the Board of Directors

09/22/16 Agenda Packet Contents

REGULAR MEETING OF THE BOARD OF DIRECTORS

AGENDA

Thursday, September 22, 2016 at 4:00 p.m.

Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT AUDIENCE**
   This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Clerk of the Board 24 hours prior to the meeting to allow for distribution.

5. **CLOSED SESSION**
   - **5.1. Report Involving Trade Secrets (Health & Safety Code § 32106)**
     Proposed New Program: One (1) item
     Estimated date of public disclosure: June 2017

   - **5.2. TIMED ITEM – 4:45PM – Conference with Real Property Negotiator (Gov. Code § 54956.8)◈**
     Property Addresses: 10956 Donner Pass Road # 130, Truckee, CA; 11015 Donner Pass Road, Truckee, CA; 10051 Lake Avenue, Truckee, CA; 10875 Pioneer Trail, Truckee, CA; 10338 River Park Place, Truckee, CA
     Agency Negotiator: Rick McConn for all properties
     Negotiating Parties: Deborah Brown & Christopher Arth; Heather Crosse; Mountain Medical LLC; Hidden Lake Properties, Inc. dba Pioneer Commerce Center; CIP Real Estate of CA, LLC
     Under Negotiation: Price & Terms of Payment for all properties

   - **5.3. Conference with Labor Negotiator (Gov. Code § 54957.6)**
     Agency Negotiator to Attend Closed Session: Jayne O'Flanagan
     Employee Organization: Employees Association of Professionals and Employees Association

   - **5.4. Report Involving Trade Secrets (Health & Safety Code § 32106)**
     Proposed New Program: One (1) item
     Estimated date of public disclosure: September 2016

   - **5.5. TIMED ITEM – 5:30PM – Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Medical Staff Credentials

   - **5.6. Approval of Closed Session Minutes◈**
     08/24/2016, 08/25/2016

6. **DINNER BREAK**

◈ Denotes Action Item

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

10. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

This is an opportunity for members of the Employee Associations to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes.

12. ACKNOWLEDGMENTS

12.1. 2016 CALNOC Annual Performance Excellence Awards
12.2. September Employee of the Month

13. MEDICAL STAFF REPORT◈

13.1. Medical Staff Report ..... ATTACHMENT*

14. CONSENT CALENDAR◈

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

14.1. Approval of Minutes of Meetings◈
08/24/2016, 08/25/2016 ..... ATTACHMENT
14.2. Financial Report◈
14.2.1. Financial Report- August 2016 ..... ATTACHMENT
14.3. Contracts◈
14.3.1. Robert Mancuso, M.D. – Professional Services Agreement ..... ATTACHMENT
14.3.2. David Kitts, M.D. – Professional Services Agreement ..... ATTACHMENT
14.3.3. Ephraim Dickinson, M.D. – Professional Services Agreement ..... ATTACHMENT
14.3.4. Kevin Cahill, M.D. – First Amendment to Call Coverage Agreement ..... ATTACHMENT
14.4. Resolutions◈
14.4.1. 2016-08 Ad Hoc Committee for Auditor Selection ..... ATTACHMENT
14.5. Tahoe Forest Health System Foundation◈
14.5.1. Quarterly Foundation Update ..... ATTACHMENT
14.5.2. Board Member Nominations ..... ATTACHMENT
14.6. Medical Staff Bylaws Revisions◈
14.6.1. Medical Staff Bylaws ..... ATTACHMENT
14.6.2. Medical Staff Rules and Regulations ..... ATTACHMENT

◈ Denotes Action Item

15. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

15.1. TFHD Professional Courtesy Policy◈ ..... ATTACHMENT
The Board of Directors will review and consider for approval a Professional Courtesy Discount Policy.

15.2. Memorandum of Understanding (MOU) for Employee Associations◈
The Board of Directors will review and consider for approval of a Memorandum of Understanding for each of the Employee Associations.

15.2.1. Memorandum of Understanding for Employees Association of Professionals ..... ATTACHMENT

15.2.2. Memorandum of Understanding for Employees Association..... ATTACHMENT*

15.3. Memorandum of Understanding◈ ..... ATTACHMENT
The Board of Directors will review and consider for approval of a Memorandum of Understanding for Grant Award to the North Tahoe Family Resource Center and Family Resource Center of Truckee Tahoe.

15.4. EPIC Contract◈ ..... ATTACHMENT*
The Board of Directors will review and consider for approval a contract for Mercy to provide EPIC Electronic Health Record system to TFHD.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

17. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

17.1. Community Benefit Committee Meeting – 09/08/2016 ..... ATTACHMENT

17.2. Governance Committee Meeting – 09/14/2016..... ATTACHMENT

17.3. Finance Committee Meeting – No meeting held in September.

17.4. Quality Committee Meeting – No meeting held in September.

17.5. Personnel Committee Meeting – No meeting held in September.

18. INFORMATIONAL REPORTS

These reports are provided for information only and not intended for discussion. Any Board Member may request discussion on an item, additional information from staff related to items included in a report, or request a topic be placed on a future agenda for further discussion.

18.1. CEO Strategic Updates ..... ATTACHMENT
CEO will provide updates related to his key strategic initiatives.

18.2. Staff Report(s)

18.2.1. CIO Board Report..... ATTACHMENT

18.2.2. CNO Board Report ..... ATTACHMENT

18.2.3. COO Board Report ..... ATTACHMENT

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

20. ITEMS FOR NEXT MEETING

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

22. CLOSED SESSION CONTINUED

◈ Denotes Action Item

22.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Report of quality assurance/medical audit committee – Patient Safety Report

22.2. Conference with Legal Counsel; Anticipated Litigation (Gov. Code § 54956.9(d)(2) & (d)(3))

A point has been reached where, in the opinion of the District Board, on the advice of its legal counsel, based on the below-described existing facts and circumstances, there is a significant exposure to litigation against the District.

Facts and circumstances that might result in litigation but which the District believes are not yet known to potential plaintiff or plaintiffs. (Gov. Code § 54956.9(e)(1))

23. OPEN SESSION

24. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY

25. MEETING EFFECTIVENESS ASSESSMENT.....ATTACHMENT

The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

26. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is October 27, 2016 at 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

◈ Denotes Action Item

Rochefort, Martina

Subject: FW: Congratulations on your Exemplary Work - 2016 CALNOC Annual Performance Excellence Awards

Subject: Congratulations on your Exemplary Work - 2016 CALNOC Annual Performance Excellence Awards

CALNOC
Advancing global patient care excellence.

August 9, 2016

Judy Newland

Tahoe Forest Hospital

PO Box 759

Truckee, California 96160

Dear Judy,

I hope this letter finds you well. On behalf of everyone at CALNOC, thank you for your continued support of our organization. We appreciate your business and commitment to patient safety and quality.

It our pleasure to recognize **Tahoe Forest Hospital** for Performance Excellence in:

Best Performance in Preventing Hospital Acquired Pressure Ulcers

Best Performance in Preventing Hospital Acquired Infections – CLABSI Total Facility

Best Performance in Preventing Hospital Acquired Infections – CLABSI Critical Care

Best Performance in Preventing Hospital Acquired Infections – CAUTI Critical Care

Best Performance in Preventing Hospital Acquired Infections – MRSA Total Facility

** See the explanation of the awards and their criteria in the below addendum.*

Your excellent work and efforts are exemplary and to be commended! We will be honoring all of our winners at our 20th Anniversary Conference on October 23-25, 2016 at the Monterey Plaza Hotel & Spa Monterey, California. We hope that you or your representative will register to attend the Conference at www.calnoc.org/page/AnnualConference so that you may accept the award on behalf of your facility, as well as join us for this event.

This year's awards presentation will include one (1) photo of your hospital or team to represent your facility's remarkable achievement. Please send your preferred photo via email to corinne.skaric@calnoc.org by Friday, September 16th. If we do not receive your photo by this date, your hospital's logo will be presented as it appears on your website.

Congratulations on an outstanding achievement and I look forward to seeing you in Monterey, at our 20th Anniversary Conference on October 23-25, 2016.

Best regards,

Tony Sung

CEO

CALNOC | 2410 Camino Ramon, Suite #360 | San Ramon, CA 94583 | 888-586-1994

2016 CALNOC Annual Performance Excellence Awards

The Collaborative Alliance for Nursing Outcomes (CALNOC) is pleased to recognize hospitals for their exemplary work in reducing hospital acquired conditions in 2015.

Award Criteria:

Best Performance in Preventing Injury Falls

Measure: Percent of Reported Falls Resulting in Moderate+ Injury or Greater (Adult Acute Care)

Award Criteria:

ADC <200: Zero Moderate or greater Injury Falls All 4 quarters

ADC 200+: Zero Moderate or Greater Injury Falls 3 or more quarters, or average for year < 1%

Best Performance in Preventing Hospital Acquired Pressure Ulcers

Measure: Percent of Patients with Hospital Acquired Pressure Ulcers Stage II or Greater (Adult Acute Care)

Award Criteria (all hospitals):

1. Risk Adjusted HAPU II+ "Better than Expected" *

   OR

2. Zero HAPU II+ All 4 Quarters

Best Performance in Preventing Hospital Acquired Infections

Measures: CLABSI Total Facility, CLABSI Critical Care, CAUTI Critical Care, Clostridium difficile Total Facility, MRSA Total Facility

Award Criteria:

ADC < 200:

All 4 Quarters show:

1. SIR (Standardized Infection Ratios) below CALNOC 25th percentile,

OR

2. Zero infections.

ADC 200+

All 4 quarters show:

1. SIR (Standardized Infection Ratios) below CALNOC 25th percentile,

OR

2. Zero infections

And the remaining quarter (if applicable) with SIR below CALNOC 50th percentile

*2015 Data predicted in risk adjustment analysis by patient characteristics and 2013-2014 performance. *Note: For HAPU II+ hospitals are not separated by ADC. Risk Adjustment applies to all hospitals, but is most applicable to large and medium hospitals if "expected" number of patients with HAPU II+ is 5 or more.*

Employee of the Month, September 2016
Natalie Buchman, CLS – Laboratory

We are honored to announce Natalie Buchman, CLS, Laboratory as our September Employee of the Month. Natalie previously worked as a Laboratory Systems Specialist where she was sent away for a week of training on a major LIS upgrade. Under pressure of the changes occurring within her department, Natalie's smile never falters. She contributes her energy, enthusiasm, and optimism to the department and always maintains a positive attitude when things get stressful. Natalie has impressed her co-workers in her ability to educating others by providing a helpful and concise presentation of new information. She reassures her fellow colleagues in the many changes that are occurring and the benefits the new system will have.

Natalie exhibits quality, understanding, and stewardship in her work to educate and inform her fellow coworkers and is a true team player in her belief that with a positive attitude the entire department can overcome the challenges they face with the system upgrade.

Natalie meets and exceeds the definition of the TFHD mission and values but most of all has been a key leader in the Diabetes programs in our community.

Please join us in congratulating all of our Terrific Nominee!

Linda Esparza- Coordinator CT and DI, Diagnostic Imaging

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Wednesday, August 24, 2016 at 8:30 a.m.

Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

Meeting was called to order at 8:31 a.m.

2. ROLL CALL

Board: Charles Zipkin, Board President; Gregory Jellinek, Vice President; Dale Chamblin, Treasurer; John Mohun, Secretary; Karen Sessler, Board Member

Staff: Harry Weis, CEO; Crystal Betts, CFO; Jake Dorst, CIO; Judy Newland, COO; Karen Gancitano, CNO; Ted Owens, Executive Director of Governance and Community Benefit; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT – AUDIENCE

No public comment was received.

5. CLOSED SESSION

5.1. Report Involving Trade Secrets (Health & Safety Code § 32106)

Proposed New Program: One (1) item
Estimated date of public disclosure: 03/31/2017

Discussion was held on a privileged item.

6. OPEN SESSION

7. BOARD MEMBERS REPORTS/CLOSING REMARKS

None.

8. MEETING EFFECTIVENESS ASSESSMENT

No discussion was held on this item.

9. ADJOURN

Meeting adjourned at 11:28 a.m.

REGULAR MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Thursday, August 25, 2016 at 4:00 p.m.
Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 4:02 p.m.

2. ROLL CALL
Board: Charles Zipkin, Board President; Gregory Jellinek, Vice President; Dale Chamblin, Treasurer; John Mohun, Secretary; Karen Sessler, Board Member

Staff: Harry Weis, CEO; Crystal Betts, CFO; Judy Newland, COO; Karen Gancitano, CNO; Ted Owens, Executive Director of Governance and Community Benefit; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
Timed item 5.7 will be scheduled for 5:45 p.m.

4. INPUT AUDIENCE
No public comment was received.

5. CLOSED SESSION
Discussion was held on privileged matters.

6. DINNER BREAK
APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 6:11 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel stated the Board only got halfway through item 5.6 and 5.7. There were no reportable actions taken and the Board will be returning back into Closed Session as part of item 22 to hear items 5.6 and 5.8.

9. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

10. INPUT – AUDIENCE
No public comment received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment received.

12. ACKNOWLEDGMENTS

12.1. "Best Of North Lake Tahoe and Truckee" Community Awards

12.2. Becker's Hospital Review named Harry Weis as Top 50 Critical Access Hospital CEO's to Know

12.3. TFHD August Employee of the Month was Charlotte Hoffman.

13. MEDICAL STAFF REPORT

13.1. Medical Staff Report

Discussion was held.

No public comment was received.

ACTION: Motion made by Director Jellinek, seconded by Director Mohun, to accept the Medical Staff Report as presented.
AYES: Directors Sessler, Mohun, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

14. CONSENT CALENDAR

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

14.1. Approval of Minutes of Meetings

07/28/2016

14.2. Financial Report

14.2.1. Financial Report - July 2016

ACTION: Motion made by Director Zipkin, seconded by Director Mohun, to accept the Consent Calendar as presented.
AYES: Directors Sessler, Mohun, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

15. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

15.1. Corporate Compliance Program Report

Jim Hook of The Fox Group presented the 2nd Quarter 2016 Corporate Compliance Program Report.

Discussion was held.

15.2. Professional Corporation Creation

The Board of Directors reviewed and considered for approval the creation of a Friendly Professional Corporation (PC) for the District.

Discussion was held.

No public comment was received.

ACTION: **Motion made by Director Zipkin, seconded by Director Chamblin, to authorize the CEO to move towards creating a Friendly Professional Corporation (PC) as presented.**

Discussion was held.

AYES: Directors Sessler, Mohun, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

None.

17. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

17.1. Quality Committee Meeting – 08/16/2016

Director Jellinek provided an update from the recent Quality Committee meeting.

17.2. Personnel Committee Meeting – 08/08/2016

Director Zipkin provided an update from the recent Personnel Committee meeting.

17.3. Finance Committee Meeting – 08/24/2016

Director Chamblin provided an update from the recent Finance Committee meeting.
Discussion was held.

17.4. Community Benefit Committee Meeting – No meeting held in August.

17.5. Governance Committee Meeting – No meeting held in August.

18. INFORMATIONAL REPORTS

These reports are provided for information only and not intended for discussion. Any Board Member may request discussion on an item, additional information from staff related to items included in a report, or request a topic be placed on a future agenda for further discussion.

18.1. CEO Strategic Updates

CEO provided updates related to his key strategic initiatives.

18.2. Staff Report(s)

18.2.1. COO Board Report
18.2.2. CNO Board Report
18.2.3. CIO Board Report

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

None.

20. ITEMS FOR NEXT MEETING

Special Meeting for CEO Performance Evaluation next month.

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

None.

Open Session recessed at 7:30 p.m.

22. CLOSED SESSION CONTINUED, IF NECESSARY

Closed Session was continued for items 5.6 and 5.8.

23. OPEN SESSION
Open Session reconvened at 7:59 p.m.

24. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
No reportable action was taken in the additional Closed Session on item 5.6 and the Closed Session Minutes of July 28, 2016 were approved 5-0.

25. MEETING EFFECTIVENESS ASSESSMENT
No discussion was held on this item.

26. ADJOURN
Meeting adjourned at 8:02 p.m.

TAHOE FOREST HOSPITAL DISTRICT
AUGUST 2016 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

AUGUST 2016 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the two months ended August 31, 2016.

Activity Statistics

- TFH acute patient days were 419 for the current month compared to budget of 367. This equates to an average daily census of 13.52 compared to budget of 11.84.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Surgical cases, Laboratory tests, Oncology Lab, Medical Oncology procedures, Ultrasounds, Cat Scans, Oncology Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Endoscopy procedures, PET CT's, Pharmacy units, and Respiratory Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 50.3% in the current month compared to budget of 54.1% and to last month's 59.3%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 54.5%, compared to budget of 54.1% and prior year's 57.3%.
- EBIDA was $1,644,366 (7.2%) for the current month compared to budget of $1,327,057 (6.2%), or $317,310 (1.0%) above budget.
- Cash Collections for the current month were $10,885,297 which is 88% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 56.7, compared to the prior month of 59.7. Gross Accounts Receivables are $35,432,293 compared to the prior month of $33,639,745. The percent of Gross Accounts Receivable over 120 days old is 20.4%, compared to the prior month of 21.3%.

Balance Sheet

- Working Capital Days Cash on Hand is 32.0 days. S&P Days Cash on Hand is 191.5. Working Capital cash increased $3,007,000. Cash collections fell short of target by 12%. Accounts Payable decreased $542,000 and Accrued Payroll & Related Liabilities increased $765,000. The District received payment of $1,508,000 on its FY2015 Meaningful Use receivable and reimbursement in the amount of $690,025 from funds advanced on July Measure C projects.
- Net Patients Accounts Receivable decreased approximately $579,000. Cash collections were at 88% of target and days in accounts receivable were 56.7 days, a 3.00 days decrease.
- Estimated Settlements, Medi-Cal & Medicare decreased a net $1,436,000. The District received payment of $1,508,000 against the Meaningful Use receivable booked at the close of FY2015.
- G.O. Bond Project Fund decreased $690,025 after reimbursing the District for July advancements on the Measure C projects.
- Funds were transferred from the District's Operating account to the G.O. Bond Tax Revenue account after receiving the final FY15/16 property tax revenues from Placer County.
- Accounts Payable decreased $542,000 due to the timing of the final check run in August,
- Accrued Payroll & Related Costs increased $765,000 due to eleven accrual days in August.

August 2016 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $22,855,003, compared to budget of $21,459,678 or $1,395,325 above budget.
- Current month's Gross Inpatient Revenue was $6,572,070, compared to budget of $5,886,492 or $685,578 over budget.
- Current month's Gross Outpatient Revenue was $16,282,934 compared to budget of $15,573,187 or $709,747 above budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 37.6% Medicare, 18.5% Medi-Cal, .0% County, 2.8% Other, and 41.1% Insurance compared to budget of 33.9% Medicare, 17.5% Medi-Cal, .0% County, 3.8% Other, and 44.8% Insurance. Last month's mix was 34.8% Medicare, 16.4% Medi-Cal, .0% County, 3.9% Other, and 44.9% Insurance.
- Current month's Deductions from Revenue were $11,363,011 compared to budget of $9,844,505 or $1,518,506 over budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 3.70% increase in Medicare, a .94% increase to Medi-Cal, a .0% decrease in County, a .99% decrease in Other, and Commercial was under budget 3.65%, 2) Revenues exceeded budget by 6.5%, and 3) Bad Debt fell short of budget by 50.0%.

Operating Expenses

DESCRIPTION	August 2016 Actual	August 2016 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,975,298	3,941,557	(33,741)	
Employee Benefits	1,234,139	1,214,863	(19,276)	
Benefits – Workers Compensation	54,550	57,011	2,462	
Benefits – Medical Insurance	647,701	694,217	46,516	
Professional Fees	1,789,242	1,798,520	9,279	MSC PSA's for Pediatrics, Cardiology, I.M./Pulmonology, and Sports Medicine, Outsourced call coverage for Orthopedics, and Legal fees for Corporate Compliance came in below budget. These positive variances were offset, in part, by negative variances in Miscellaneous for Professional and Legal fees for TIRHR, and fees for the Interim Director of Physician Services.
Supplies	1,904,405	1,786,333	(118,072)	Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues exceeded budget by 16.55%, creating a negative variance in Pharmacy Supplies.
Purchased Services	740,090	875,525	135,435	Outsourced Laboratory testing and services budgeted for the GUGC tournament, Wellness Neighborhood, and Laundry & Linen services came in below budget. The District changed linen services vendors and received two weeks of free linen delivery, helping to achieve the positive variance in Purchased Services.
Other Expenses	449,147	595,215	146,068	Controllable expenses are being monitored closely by senior management, creating positive variances in most of the Other Expenses categories.
Total Expenses	10,794,570	10,963,240	168,670	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
AUGUST 2016

	PRELIMINARY Aug-16	PRELIMINARY Jul-16	Aug-15	
ASSETS				
CURRENT ASSETS				
* CASH	$ 11,227,731	$ 8,220,836	$ 13,009,477	1
PATIENT ACCOUNTS RECEIVABLE - NET	18,279,356	18,858,367	15,306,144	2
OTHER RECEIVABLES	4,936,470	4,597,098	4,323,038	
GO BOND RECEIVABLES	1,031	(285,433)	398,788	
ASSETS LIMITED OR RESTRICTED	6,286,244	6,344,728	5,143,103	
INVENTORIES	2,685,837	2,690,052	2,312,070	
PREPAID EXPENSES & DEPOSITS	1,662,606	1,796,229	1,638,053	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,238,178	4,673,727	3,899,303	3
TOTAL CURRENT ASSETS	48,317,454	46,895,604	46,029,976	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	55,958,822	55,958,822	40,759,110	1
BANC OF AMERICA MUNICIPAL LEASE	981,619	981,619	979,068	
TOTAL BOND TRUSTEE 2002	3	3	2	
TOTAL BOND TRUSTEE 2015	350,701	222,350	382,220	
GO BOND PROJECT FUND	232,576	922,601	11,669,585	4
GO BOND TAX REVENUE FUND	1,314,624	1,124,150	662,645	5
BOARD DESIGNATED FUND	-	-	2,297	
DIAGNOSTIC IMAGING FUND	3,164	3,164	2,971	
DONOR RESTRICTED FUND	1,140,621	1,140,621	1,157,248	
WORKERS COMPENSATION FUND	26,288	25,591	10,613	
TOTAL	60,008,418	60,378,921	55,625,758	
LESS CURRENT PORTION	(6,286,244)	(6,344,728)	(5,143,103)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	53,722,174	54,034,193	50,482,655	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	43,372	43,372	324,395	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	128,604,066	128,600,673	130,297,190	
GO BOND CIP, PROPERTY & EQUIPMENT NET	30,322,444	29,763,818	21,246,865	
TOTAL ASSETS	261,845,862	260,174,013	249,217,434	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	536,574	539,807	575,363	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	2,281,527	2,281,527	1,774,439	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	1,909,394	1,917,032	2,001,045	
GO BOND DEFERRED FINANCING COSTS	296,070	297,254	310,281	
DEFERRED FINANCING COSTS	210,136	211,176	222,619	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 5,233,701	$ 5,246,796	$ 4,883,747	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,411,900	$ 6,953,649	$ 5,554,034	6
ACCRUED PAYROLL & RELATED COSTS	9,115,781	8,350,651	7,614,695	7
INTEREST PAYABLE	208,039	116,078	227,023	
INTEREST PAYABLE GO BOND	315,492	-	358,673	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	64,521	102,300	366,399	
HEALTH INSURANCE PLAN	1,307,731	1,307,731	1,307,731	
WORKERS COMPENSATION PLAN	1,120,980	1,120,980	404,807	
COMPREHENSIVE LIABILITY INSURANCE PLAN	751,298	751,298	824,203	
CURRENT MATURITIES OF GO BOND DEBT	975,000	975,000	530,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,361,788	2,361,788	2,323,994	
TOTAL CURRENT LIABILITIES	22,632,530	22,039,475	19,511,559	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	28,254,436	28,359,130	30,630,641	
GO BOND DEBT NET OF CURRENT MATURITIES	98,725,608	98,729,550	100,032,917	
DERIVATIVE INSTRUMENT LIABILITY	2,281,527	2,281,527	1,774,439	
TOTAL LIABILITIES	151,894,101	151,409,682	151,949,556	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	114,044,841	112,870,506	100,994,377	
RESTRICTED	1,140,621	1,140,621	1,157,248	
TOTAL NET POSITION	$ 115,185,462	$ 114,011,127	$ 102,151,625	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
AUGUST 2016 PRELIMINARY

1. Working Capital is at 32.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 191.5 days. Working Capital cash increased a net $3,007,000. Cash collections fell short of target by 12%, however, were 35% higher than July collections. Accounts Payable (See Note 6) decreased $542,000 and Accrued Payroll & Related Costs (See Note 7) increased $765,000. The District received payment of $1,508,000 on the Meaningful Use receivable (See Note 3) booked at the close of FY2015 and reimbursement from the G.O. Bond Project Fund (See Note 4) in the amount of $690,025.

2. Net Patient Accounts Receivable decreased approximately $579,000. Cash collections were 88% of target. Days in Accounts Receivable are at 56.7 days compared to prior months 59.7 days, a 3.0 days decrease.

3. Estimated Settlements, Medi-Cal & Medicare decreased a net $1,436,000. The District received its Meaningful Use reimbursement in the amount of $1,508,000 that was booked as a receivable at the close of FY2015.

4. G.O. Bond Project Fund decreased $690,025 after remitting reimbursement to the District for funds advanced on the July Measure C projects.

5. G.O. Bond Tax Revenue Fund increased $190,000. Funds were transferred from the District's Operating Fund once the final FY15/16 property tax revenues were received from Placer County.

6. Accounts Payable decreased $542,000 due to the timing of the final check run in August.

7. Accrued Payroll & Related Costs increased $765,000 due to eleven accrual days in August.

Tahoe Forest Hospital District
Cash Investment
August 2016

WORKING CAPITAL				
US Bank	$ 10,951,172			
US Bank/Kings Beach Thrift Store	80,149			
US Bank/Truckee Thrift Store	196,410			
US Bank/Payroll Clearing	-			
Local Agency Investment Fund	-	0.61%		
Total			$	11,227,731
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	55,958,822	0.61%		
Local Agency Investment Fund			$	55,958,822
Banc of America Muni Lease			$	981,619
Bonds Cash 2002			$	3
Bonds Cash 2015			$	350,701
Bonds Cash 2008			$	1,547,201
DX Imaging Education	$ 3,164	0.61%		
Workers Comp Fund - B of A	26,288			
Insurance				
Health Insurance LAIF	-	0.61%		
Comprehensive Liability Insurance LAIF	-	0.61%		
Total			$	29,451
TOTAL FUNDS			$	70,095,528
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,363	0.03%		
Foundation Restricted Donations	$ 98,331			
Local Agency Investment Fund	1,033,927	0.61%		
TOTAL RESTRICTED FUNDS			$	1,140,621
TOTAL ALL FUNDS			$	71,236,149

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
AUGUST 2016

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD AUG 2015
					OPERATING REVENUE						
$ 22,855,003	$ 21,459,678	$ 1,395,325	6.5%		Total Gross Revenue	$ 43,350,467	$ 42,297,786	$ 1,052,681	2.5%	1	$ 37,475,170
					Gross Revenues - Inpatient						
$ 2,073,868	$ 1,867,109	$ 206,759	11.1%		Daily Hospital Service	$ 4,134,579	$ 3,694,254	$ 440,325	11.9%		$ 3,158,469
4,498,202	4,019,382	478,819	11.9%		Ancillary Service - Inpatient	8,005,726	7,883,373	122,353	1.6%		6,213,696
6,572,070	5,886,492	685,578	11.6%		Total Gross Revenue - Inpatient	12,140,304	11,577,627	562,678	4.9%	1	9,372,165
16,282,934	15,573,187	709,747	4.6%		Gross Revenue - Outpatient	31,210,163	30,720,159	490,004	1.6%		28,103,005
16,282,934	15,573,187	709,747	4.6%		Total Gross Revenue - Outpatient	31,210,163	30,720,159	490,004	1.6%	1	28,103,005
					Deductions from Revenue:						
10,438,111	8,767,773	(1,670,338)	-19.1%		Contractual Allowances	18,349,196	17,276,170	(1,073,026)	-6.2%	2	15,121,410
746,095	751,961	5,866	0.8%		Charity Care	1,341,690	1,482,419	140,729	9.5%	2	1,153,824
16,420	-	(16,420)	0.0%		Charity Care - Catastrophic Events	16,420	-	(16,420)	0.0%	2	-
162,386	324,771	162,386	50.0%		Bad Debt	7,273	641,529	634,257	98.9%	2	(282,318)
-	-	-	0.0%		Prior Period Settlements	(131)	-	131	0.0%	2	-
11,363,011	9,844,505	(1,518,506)	-15.4%		Total Deductions from Revenue	19,714,448	19,400,118	(314,330)	-1.6%		15,992,916
35,134	55,401	(20,266)	-36.6%		Property Tax Revenue- Wellness Neighborhood	74,927	113,504	(38,577)	-34.0%		88,600
911,810	619,723	292,087	47.1%		Other Operating Revenue	1,764,382	1,431,089	333,293	23.3%	3	1,200,512
12,438,937	12,290,297	148,640	1.2%		TOTAL OPERATING REVENUE	25,475,328	24,442,260	1,033,068	4.2%		22,771,366
					OPERATING EXPENSES						
3,975,298	3,941,557	(33,741)	-0.9%		Salaries and Wages	7,942,968	7,907,476	(35,492)	-0.4%	4	7,036,632
1,234,139	1,214,863	(19,276)	-1.6%		Benefits	2,557,932	2,539,804	(18,129)	-0.7%	4	2,791,648
54,550	57,011	2,462	4.3%		Benefits Workers Compensation	100,874	114,022	13,148	11.5%	4	91,477
647,701	694,217	46,516	6.7%		Benefits Medical Insurance	1,254,319	1,388,434	134,115	9.7%	4	774,238
1,789,242	1,798,520	9,279	0.5%		Professional Fees	3,771,246	3,597,018	(174,227)	-4.8%	5	3,045,812
1,904,405	1,786,333	(118,072)	-6.6%		Supplies	3,425,727	3,568,570	142,843	4.0%	6	2,872,085
740,090	875,525	135,435	15.5%		Purchased Services	1,675,272	1,817,992	142,721	7.9%	7	1,682,499
449,147	595,215	146,068	24.5%		Other	827,167	1,112,110	284,943	25.6%	8	714,347
10,794,570	10,963,240	168,670	1.5%		TOTAL OPERATING EXPENSE	21,555,505	22,045,427	489,922	2.2%		19,008,738
1,644,366	**1,327,057**	**317,310**	**23.9%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**3,919,823**	**2,396,834**	**1,522,990**	**63.5%**		**3,762,628**
					NON-OPERATING REVENUE/(EXPENSE)						
471,366	451,099	20,266	4.5%		District and County Taxes	938,073	899,496	38,577	4.3%	9	815,814
391,933	391,933	-	0.0%		District and County Taxes - GO Bond	783,867	783,867	-	0.0%		785,383
45,102	31,324	13,778	44.0%		Interest Income	90,003	60,723	29,280	48.2%	10	51,653
4	-	4	0.0%		Interest Income-GO Bond	9	-	9	0.0%		6,109
11,745	38,917	(27,172)	-69.8%		Donations	30,457	77,833	(47,376)	-60.9%	11	14,157
-	-	-	0.0%		Gain/ (Loss) on Joint Investment	-	-	-	0.0%	12	-
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(967,356)	(966,316)	(1,040)	-0.1%		Depreciation	(1,934,713)	(1,932,632)	(2,081)	-0.1%	15	(1,711,427)
(102,453)	(100,157)	(2,296)	-2.3%		Interest Expense	(203,455)	(200,616)	(2,839)	-1.4%	16	(237,148)
(320,371)	(315,492)	(4,879)	-1.5%		Interest Expense-GO Bond	(640,742)	(630,984)	(9,759)	-1.5%		(731,808)
(470,031)	(468,691)	(1,340)	-0.3%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(936,501)	(942,313)	5,812	0.6%		(1,007,267)
$ 1,174,335	**$ 858,366**	**$ 315,970**	**-36.8%**		**INCREASE (DECREASE) IN NET POSITION**	**$ 2,983,322**	**$ 1,454,521**	**$ 1,528,801**	**-105.1%**		**$ 2,755,361**
					NET POSITION - BEGINNING OF YEAR	**112,202,140**					
					NET POSITION - AS OF AUGUST 31, 2016	**$ 115,185,462**					
7.2%	**6.2%**	**1.0%**			**RETURN ON GROSS REVENUE EBIDA**	**9.0%**	**5.7%**	**3.4%**			**10.0%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
AUGUST 2016 PRELIMINARY

		Variance from Budget Fav / <Unfav> AUG 2016	YTD 2017
1) Gross Revenues			
Acute Patient Days were above budget 14.17% or 52 days. Swing Bed days were under budget 18.18% or 6 days. Inpatient Ancillary revenues exceeded budget by 11.9% due to the increase in our Acute Patient Days.	Gross Revenue -- Inpatient	$ 685,578	$ 562,678
	Gross Revenue -- Outpatient	709,747	490,004
	Gross Revenue -- Total	$ 1,395,325	$ 1,052,681
Outpatient volumes were above budget in the following departments: Surgical cases, Laboratory tests, Oncology Lab, Mammography, Oncology procedures, Ultrasounds, Cat Scans, Oncology Drugs, Physical Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for August shows a 3.70% increase to Medicare, a .94% increase to Medi-Cal, .99% decrease to Other, County at budget, and a 3.65% decrease to Commercial when compared to budget. Contractual Allowances were over budget as a result of revenues exceeding budget by 6.50% and the shift in payor mix from Commercial to Medicare and Medi-Cal.	Contractual Allowances	$ (1,670,338)	$ (1,073,026)
	Charity Care	5,866	140,729
	Charity Care - Catastrophic	(16,420)	(16,420)
	Bad Debt	162,386	634,257
	Prior Period Settlements	-	131
	Total	$ (1,518,506)	$ (314,330)
3) Other Operating Revenue			
Retail Pharmacy revenues exceeded budget by 16.53%.	Retail Pharmacy	$ 39,883	$ 99,694
	Hospice Thrift Stores	8,466	21,078
Hospice Thrift Store revenues exceeded budget by 9.37%.	The Center (non-therapy)	(12,606)	(24,752)
	IVCH ER Physician Guarantee	31,288	31,517
	Children's Center	7,815	(938)
Sports Performance training, Occupational Health testing, Fitness Center memberships, and Pilates/Personal Training classes came in below budget, creating a negative variance in The Center (non-therapy).	Miscellaneous	217,241	206,694
	Oncology Drug Replacement	-	-
	Grants	-	-
	Total	$ 292,087	$ 333,293
Child Care Center revenues exceeded budget by 10.70%.			
North Tahoe Orthopedic Clinic A/R collection receivable and State of California Quality Assurance fees created a positive variance in Miscelleanous.			
4) Salaries and Wages	Total	$ (33,741)	$ (35,492)
Employee Benefits	PL/SL	$ (62,534)	$ (72,821)
	Nonproductive	14,702	(14,244)
	Pension/Deferred Comp	(16,086)	(1,651)
	Standby	25,377	39,467
	Other	19,265	31,121
	Total	$ (19,276)	$ (18,129)
Employee Benefits - Workers Compensation	Total	$ 2,462	$ 13,148
Employee Benefits - Medical Insurance	Total	$ 46,516	$ 134,115
5) Professional Fees	Multi-Specialty Clinics	$ 40,545	$ (89,114)
Positive variance in Multi-Specialty Clinics related to MSC Pediatrics, Cardiology, I.M./Pulmonology, and Sports Medicine budgeted PSA's falling below budget.	Miscellaneous	(52,530)	(67,676)
	Administration	2,940	(34,547)
	Multi-Specialty Clinics Admin	(25,567)	(25,931)
Negative variance in Miscellaneous for Professional Fees and Legal Fees paid on behalf of TIRHR.	Oncology	(9,557)	(10,394)
	Information Technology	(6,616)	(7,920)
	IVCH ER Physicians	1,540	(3,045)
Negative variance in Multi-Specialty Clinics Admin for the Interim Director of Physician Services.	Home Health/Hospice	(1,950)	(1,900)
	Medical Staff Services	(2,249)	(699)
	Patient Accounting/Admitting	-	-
Positive variance in TFH Locums coverage related to outsourced Orthopedic Call coverage falling below budget.	Business Performance	-	-
	Respiratory Therapy	-	-
	The Center (includes OP Therapy)	(5,775)	761
Legal Fees provided to Corporate Compliance fell short of budget, creating a positive variance in this category.	Financial Administration	585	2,370
	Marketing	2,375	4,750
	Human Resources	8,203	5,048
	Managed Care	9,000	6,341
	TFH/IVCH Therapy Services	1,994	6,999
	TFH Locums	22,879	9,686
	Corporate Compliance	13,837	14,171
	Sleep Clinic	9,624	16,874
	Total	$ 9,279	$ (174,227)

6) Supplies Drugs Sold to Patients and Oncology Drugs Sold to Patients revenue exceeded budget by 16.55%, creating a negative variaince in Pharmacy Supplies. Surgery revenues exceeded budget by 9.01%, however, the mix of cases, inclusive of fewer orthopedic cases, created a positive variance in Patient & Other Medical Supplies.	Minor Equipment	$ (5,757)	$ (15,242)
	Food	(9,161)	(10,082)
	Imaging Film	913	1,594
	Other Non-Medical Supplies	(649)	12,091
	Pharmacy Supplies	(131,571)	12,571
	Office Supplies	9,473	16,257
	Patient & Other Medical Supplies	18,680	125,654
	Total	$ (118,072)	$ 142,843
7) Purchased Services Positive variance in Laboratory related to outsourced lab testing services. Purchased services for the GUGC tournament, Wellness Neighborhood, and Laundry & Linen services fell below budget estimations, creating a positive variance in Miscellaneous. The District changed linen services vendors and received two weeks of free linen delivery service which aided in this categories positive variance.	Patient Accounting	$ 1,005	$ (12,095)
	Diagnostic Imaging Services - All	6,945	(6,793)
	Hospice	(752)	(3,319)
	Medical Records	252	(935)
	Multi-Specialty Clinics	6,574	(354)
	The Center	(1,035)	244
	Pharmacy IP	3,801	2,597
	Community Development	2,700	5,400
	Laboratory	12,052	7,915
	Information Technology	6,570	14,135
	Department Repairs	9,739	22,133
	Human Resources	8,846	36,381
	Miscellaneous	78,736	77,410
	Total	$ 135,435	$ 142,721
8) Other Expenses Budgeted Training & Travel expenses for Education, Administration, Personnel, and Oncology fell short of estimations, creating a positive variance in Outside Training & Travel. Dues & Subscriptions for Oncology and Administration fell short of budget, creating a positive variance in this category. Recruitment fees for the District's Chief Operating Officer fell short of budget estimations due to hiring a candidate internally. Expenses advanced for TIRHR Professional and Legal Fees were over budget in August. These expenses are reclassified to a receivable account on the Balance Sheet which created a positive variance in Miscellaneous.	Insurance	$ (2,949)	$ (4,843)
	Other Building Rent	(1,737)	(1,556)
	Innovation Fund	-	-
	Equipment Rent	(1,162)	180
	Multi-Specialty Clinics Equip Rent	125	215
	Physician Services	9	1,304
	Outside Training & Travel	16,058	1,845
	Multi-Specialty Clinics Bldg Rent	133	3,177
	Utilities	3,851	8,137
	Dues and Subscriptions	13,348	25,576
	Marketing	24,460	50,232
	Human Resources Recruitment	27,989	52,848
	Miscellaneous	65,941	147,828
	Total	$ 146,068	$ 284,943
9) District and County Taxes	Total	$ 20,266	$ 38,577
10) Interest Income	Total	$ 13,778	$ 29,280
11) Donations	IVCH	$ -	$ 3,858
	Operational	(27,172)	(51,234)
	Capital Campaign		
	Total	(27,172)	(47,376)
12) Gain/(Loss) on Joint Investment	Total	$ -	$ -
13) Gain/(Loss) on Sale	Total	$ -	$ -
15) Depreciation Expense	Total	$ (1,040)	$ (2,081)
16) Interest Expense	Total	$ (2,296)	$ (2,839)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
AUGUST 2016

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD AUG 2015
					OPERATING REVENUE						
$ 1,804,033	$ 1,808,131	$ (4,098)	-0.2%		Total Gross Revenue	$ 3,578,179	$ 3,619,684	$ (41,506)	-1.1%	1	$ 3,527,397
					Gross Revenues - Inpatient						
$ 8,559	$ 2,914	$ 5,645	193.7%		Daily Hospital Service	$ 11,624	$ 2,914	$ 8,710	298.9%		$ 16,574
-	3,426	(3,426)	-100.0%		Ancillary Service - Inpatient	19,089	6,655	12,433	186.8%		24,146
8,559	6,340	2,219	35.0%		Total Gross Revenue - Inpatient	30,713	9,569	21,143	220.9%	1	40,720
1,795,474	1,801,791	(6,318)	-0.4%		Gross Revenue - Outpatient	3,547,466	3,610,115	(62,649)	-1.7%		3,486,677
1,795,474	1,801,791	(6,318)	-0.4%		Total Gross Revenue - Outpatient	3,547,466	3,610,115	(62,649)	-1.7%	1	3,486,677
					Deductions from Revenue:						
711,169	584,538	(126,631)	-21.7%		Contractual Allowances	1,283,622	1,168,129	(115,493)	-9.9%	2	1,048,161
60,342	68,087	7,745	11.4%		Charity Care	119,847	136,421	16,574	12.1%	2	120,571
16,420	-	(16,420)	0.0%		Charity Care - Catastrophic Events	16,420	-	(16,420)	0.0%	2	-
(58,771)	65,371	124,142	189.9%		Bad Debt	(30,569)	130,979	161,548	123.3%	2	140,121
-	-	-	0.0%		Prior Period Settlements	-	-	-	0.0%	2	-
729,159	717,996	(11,163)	-1.6%		Total Deductions from Revenue	1,389,320	1,435,529	46,209	3.2%	2	1,308,853
103,183	73,280	29,903	40.8%		Other Operating Revenue	175,251	146,559	28,692	19.6%	3	143,275
1,178,057	1,163,415	14,642	1.3%		TOTAL OPERATING REVENUE	2,364,110	2,330,715	33,395	1.4%		2,361,819
					OPERATING EXPENSES						
311,607	314,510	2,904	0.9%		Salaries and Wages	627,028	638,860	11,833	1.9%	4	505,480
101,996	92,476	(9,520)	-10.3%		Benefits	199,149	195,169	(3,981)	-2.0%	4	139,282
1,965	1,417	(548)	-38.7%		Benefits Workers Compensation	4,430	2,834	(1,597)	-56.3%	4	4,994
40,738	44,618	3,880	8.7%		Benefits Medical Insurance	81,837	89,237	7,400	8.3%	4	50,341
241,844	255,639	13,796	5.4%		Professional Fees	485,146	504,406	19,260	3.8%	5	504,707
58,218	92,914	34,697	37.3%		Supplies	118,423	189,163	70,740	37.4%	6	120,696
31,218	43,428	12,210	28.1%		Purchased Services	69,182	87,059	17,877	20.5%	7	87,067
53,470	55,862	2,391	4.3%		Other	91,826	109,470	17,644	16.1%	8	107,824
841,055	900,865	59,809	6.6%		TOTAL OPERATING EXPENSE	1,677,022	1,816,197	139,175	7.7%		1,520,391
337,001	**262,550**	**74,451**	**28.4%**		**NET OPERATING REV(EXP) EBIDA**	**687,088**	**514,518**	**172,570**	**33.5%**		**841,428**
					NON-OPERATING REVENUE/(EXPENSE)						
-	-	-	0.0%		Donations-IVCH	3,858	-	3,858	0.0%	9	-
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(64,277)	(64,277)	-	0.0%		Depreciation	(128,553)	(128,553)	(0)	0.0%	11	(116,718)
(64,277)	(64,277)	-	0.0%		TOTAL NON-OPERATING REVENUE/(EXP)	(124,695)	(128,553)	3,858	3.0%		(116,718)
$ 272,725	**$ 198,274**	**$ 74,451**	**37.5%**		**EXCESS REVENUE(EXPENSE)**	**$ 562,393**	**$ 385,965**	**$ 176,428**	**45.7%**		**$ 724,710**
18.7%	**14.5%**	**4.2%**			**RETURN ON GROSS REVENUE EBIDA**	**19.2%**	**14.2%**	**5.0%**			**23.9%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
AUGUST 2016 PRELIMINARY

		Variance from Budget Fav<Unfav> AUG 2016	YTD 2017
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 0 and Observation Days were above budget by 4 at 6.	Gross Revenue -- Inpatient	$ 2,219	$ 21,143
	Gross Revenue -- Outpatient	(6,318)	(62,649)
		$ (4,098)	$ (41,506)
Outpatient volumes were under budget in Emergency Department visits, Sugical cases, Radiology exams, Cat Scans, Sleep Clinic visits, Physical Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 4.18% decrease in Commercial Insurance, a 5.30% increase in Medicare, a .53% decrease in Medicaid, a .59% decrease in Other, and County was at budget. Negative variance in Contractual Allowances is a result of the shift in payor mix from Commercial to Medicare.	Contractual Allowances	$ (126,631)	$ (115,493)
	Charity Care	7,745	16,574
	Charity Care-Catastrophic Event	(16,420)	(16,420)
	Bad Debt	124,142	161,548
	Prior Period Settlement	-	-
	Total	$ (11,163)	$ 46,209
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections, which exceeded budget in August.	IVCH ER Physician Guarantee	$ 31,288	$ 31,517
	Miscellaneous	(1,384)	(2,826)
	Total	$ 29,903	$ 28,692
4) Salaries and Wages	Total	$ 2,904	$ 11,833
Employee Benefits	PL/SL	$ (9,212)	$ (8,517)
	Standby	(3,814)	(3,810)
	Other	3,362	7,847
	Nonproductive	(269)	(538)
	Pension/Deferred Comp	413	1,037
	Total	$ (9,520)	$ (3,981)
Employee Benefits - Workers Compensation	Total	$ (548)	$ (1,597)
Employee Benefits - Medical Insurance	Total	$ 3,880	$ 7,400
5) Professional Fees	IVCH ER Physicians	$ 1,540	$ (3,045)
Sleep Clinic collections fees fell short of budget in August, creating a positive variance in Sleep Clinic Pro Fees.	Foundation	37	(394)
	Administration	(366)	(103)
	Miscellaneous	1,049	1,214
	Therapy Services	432	1,755
	Multi-Specialty Clinics	1,480	2,959
	Sleep Clinic	9,624	16,874
	Total	$ 13,796	$ 19,260
6) Supplies	Food	$ (923)	$ (1,746)
Oncology Drugs Sold to Patients revenue fell short of budget by 40.36%, creating a positive variance in Pharmacy Supplies.	Non-Medical Supplies	350	252
	Office Supplies	766	445
	Imaging Film	243	511
Surgical Services and Medical Supplies Sold to Patients revenues fell short of budget by 15.44%, creating a positive variance in Patient & Other Medical Supplies.	Minor Equipment	2,538	1,753
	Pharmacy Supplies	8,198	19,643
	Patient & Other Medical Supplies	23,525	49,883
	Total	$ 34,697	$ 70,740

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
AUGUST 2016 PRELIMINARY

		Variance from Budget Fav<Unfav>	
		AUG 2016	YTD 2017
7) Purchased Services	Diagnostic Imaging Services - All	$ 520	$ (1,561)
Positive variance in EVS/Laundry is a result of switching laundry services vendors and receiving two weeks of free linen delivery services.	Pharmacy	(12)	(12)
	Surgical Services	-	-
	Multi-Specialty Clinics	159	349
Purchased services for Physical Therapy, Community Health, and Medically Managed fitness came in below budget estimates, creating a positvie variance in Miscellaneous.	Foundation	1,280	1,924
	Engineering/Plant/Communications	1,129	2,570
	EVS/Laundry	2,620	2,710
	Department Repairs	854	3,103
	Laboratory	2,310	3,955
	Miscellaneous	3,349	4,839
	Total	$ 12,210	$ 17,877
8) Other Expenses	Insurance	$ (1,872)	$ (3,745)
Negative variance in Outside Training & Travel related to educational assistance reimbursement.	Outside Training & Travel	(2,839)	(3,458)
	Physician Services	-	-
	Multi-Specialty Clinics Equip Rent	-	-
Positive variance in Miscellaneous primarily related to Laboratory transfer costs between IVCH and TFH for outsourced lab resulting.	Multi-Specialty Clinics Bldg Rent	-	-
	Other Building Rent	-	-
	Dues and Subscriptions	1,166	2,250
	Equipment Rent	(195)	2,420
	Marketing	625	3,500
	Utilities	(358)	4,011
	Miscellaneous	5,866	12,666
	Total	$ 2,391	$ 17,644
9) Donations	Total	$ -	$ 3,858
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	PRELIMINARY FYE 2016		BUDGET FYE 2017		PROJECTED FYE 2017	ACTUAL AUG 2016	BUDGET AUG 2016	DIFFERENCE	PROJECTED 1ST QTR	PROJECTED 2ND QTR	BUDGET 3RD QTR	BUDGET 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 16,721,502		$ 8,354,249		$ 10,075,235	1,644,366	$ 1,327,057	317,309	$ 4,685,766	$ 1,394,954	$ 3,062,467	$ 932,048
Interest Income	160,650		249,285		249,612	-	-	-	70,617	48,762	60,097	70,136
Property Tax Revenue	6,120,218		5,682,000		5,717,312	235,198	216,000	19,198	345,312	78,000	3,020,000	2,274,000
Donations	702,906		1,023,000		1,124,498	1,301	30,000	(28,699)	151,498	90,000	405,000	478,000
Debt Service Payments	(3,441,272)		(3,568,341)		(3,558,556)	(232,948)	(241,694)	8,746	(1,219,302)	(725,083)	(889,087)	(725,083)
Bank of America - 2012 Muni Lease	(1,243,650)		(1,243,644)		(1,243,645)	(103,637)	(103,637)	(0)	(310,912)	(310,911)	(310,911)	(310,911)
Copier	(8,758)		(11,520)		(11,518)	(959)	(960)	1	(2,878)	(2,880)	(2,880)	(2,880)
2002 Revenue Bond	(483,555)		(668,008)		(660,955)	-	-	-	(496,951)	-	(164,004)	-
2015 Revenue Bond	(1,705,309)		(1,645,169)		(1,642,437)	(128,352)	(137,097)	8,746	(408,560)	(411,292)	(411,292)	(411,292)
Physician Recruitment	(263,769)		(120,000)		(100,000)	-	(10,000)	10,000	(10,000)	(30,000)	(30,000)	(30,000)
Investment in Capital												
Equipment	(1,495,214)		(1,262,750)		(1,262,750)	(167,765)	(326,750)	158,985	(980,250)	(275,000)	(7,500)	-
Municipal Lease Reimbursement	1,319,139		979,000		979,000	-	-	-	-	979,000	-	-
GO Bond Project Personal Property	(432,135)		(279,000)		(279,000)	(207,417)	(139,500)	(67,917)	(279,000)	-	-	-
IT	(888,802)		(297,578)		(297,578)	(10,055)	(153,697)	143,642	(297,578)	-	-	-
Building Projects	(2,095,500)		(4,315,500)		(4,315,500)	(576,962)	(454,167)	(122,795)	(1,635,296)	(1,336,204)	(709,000)	(635,000)
Health Information/Business System	(92,807)		(7,000,000)		(7,000,000)	-	-	-	-	(3,000,000)	(2,000,000)	(2,000,000)
Capital Investments												
Properties	-		(2,794,000)		(2,789,000)	(30,000)	(730,000)	700,000	(40,000)	(2,320,000)	(429,000)	-
Measure C Scope Modifications	-		(2,476,716)		(2,476,716)	-	(1,013,358)	1,013,358	(2,026,716)	(450,000)	-	-
Change in Accounts Receivable	(1,119,613)		(2,183,288)	N1	(2,136,233)	579,000	(1,524,467)	2,103,467	(2,971,720)	331,796	(210,814)	714,505
Change in Settlement Accounts	1,387,101		1,175,000	N2	1,845,157	1,508,262	-	1,508,262	(1,007,843)	3,038,000	(435,000)	250,000
Change in Other Assets	(3,119,093)		(890,622)	N3	(488,354)	(46,302)	(316,000)	269,698	(302,174)	(469,762)	6,718	276,864
Change in Other Liabilities	2,950,987		(320,000)	N4	(733,379)	315,343	750,000	(434,657)	(813,379)	280,000	(800,600)	600,000
Change in Cash Balance	16,404,918		(8,045,261)		(5,446,251)	3,012,021	(2,586,576)	5,598,596	(6,330,064)	(2,365,538)	1,043,881	2,205,470
Beginning Unrestricted Cash	52,227,897		68,632,815		68,632,815	64,174,533	64,174,533	-	68,632,815	62,302,751	59,937,213	60,981,094
Ending Unrestricted Cash	68,632,815		60,778,463		63,186,564	67,186,553	61,587,957	5,598,596	62,302,751	59,937,213	60,981,094	63,186,564
Expense Per Day	338,339		355,605		354,271	350,951	358,807	(7,856)	351,704	352,112	355,353	354,271
Days Cash On Hand	203		171		178	191	172	20	177	170	172	178

Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

14.3. Contracts

Contracts redacted.

Available for public viewing via a Public Records request.

RESOLUTION NO. 2016-08

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT ESTABLISHING AN AD HOC ADVISORY COMMITTEE TO MAKE RECOMMENDATIONS TO THE BOARD OF DIRECTORS CONCERNING AUDITOR SELECTION

WHEREAS, under Health and Safety Code section 32133, the Board of Directors shall engage the services of a qualified accountant of accepted reputation to conduct an audit of the books of the hospital and prepare a report;

WHEREAS, the District regularly engages a new accountant to conduct its annual audit consistent with best practices;

WHEREAS, the District is currently requesting proposals from qualified auditors of to perform the District's annual audit; and

WHEREAS, the Board of Directors seeks to form an advisory committee for the purposes of reviewing proposals and making recommendations on or before October 27, 2016 to the Board regarding the selection of the District's auditor.

NOW, THEREFORE, BE IT RESOLVED, by the Board of Directors of the Tahoe Forest Hospital District, that:

SECTION 1. An ad hoc advisory Auditor Selection Committee is hereby established to be comprised of Directors Chamblin and Mohun.

SECTION 2. The Committee is charged with developing a recommendation to the Board of Directors with regard to selecting an accountancy firm of accepted reputation to perform the District's annual audit. The Committee shall have such support from the General Counsel and other District staff as the CEO shall direct.

SECTION 3. The Committee shall provide a recommendation to the Board of Directors on or before October 27, 2016. Upon provision of its recommendation to the Board of Directors, the Committee shall automatically be disestablished.

SECTION 4. As a temporary, ad hoc advisory committee comprised of less than a quorum of the Board of Directors, the Committee may, but need not, comply with the Brown Act as authorized by Government Code section 54952, subdivision (b).

SECTION 5. This Resolution shall take effect immediately upon its adoption.

PASSED, APPROVED AND ADOPTED at a regular meeting of the Board of Directors of the Tahoe Forest Hospital District duly called and held in the District this 22nd day of September, 2016 by the following vote:

AYES:

NOES:
ABSTAIN:
ABSENT:

APPROVED:

_____
CHARLES ZIPKIN, MD
President, Board of Directors
Tahoe Forest Hospital District

ATTEST:

_____
MARTINA ROCHEFORT, Clerk of the Board
Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

DATE: September 13, 2016

By: Martha Simon
Director, Tahoe Forest Health System Foundation (TFHSF)

Quarterly Foundation Report

- The Foundation completed two major fundraising events this calendar year: Best of Tahoe Chefs in May and the Gene Upshaw Memorial Golf Classic (GUMGC) in July. These two events will generate a net total of over $377,000 that directly supports vital programs and services for both the cancer center and TBI research. The final revenue component of the Upshaw tournament includes our annual Super Bowl Raffle. Thanks to the NFL, we are able to provide a raffle opportunity to win an all-expense paid trip to the Super Bowl in Houston, TX on February 5, 2017. Tickets are $100 each and only 300 total are sold. The drawing is Dec 26, 2016.

- Another exciting element that evolved through the leadership of Pat Allen, a member of the GUMGC Advisory Board, is the creation of a thirty minute television special highlighting the legacy of NFL Hall of Famer Gene Upshaw, to be aired on CSN (Comcast Sports Network) Bay Area in October of 2016. The show will be hosted by Dave Feldman, co-anchor of SportsNet Central, CSN Bay Area's daily sports news show. The piece is designed to build awareness around Gene Upshaw's legacy as it relates to The Gene Upshaw Memorial Tahoe Forest Cancer Center and its programs. This is an excellent opportunity intended to draw attention to Tahoe Forest Health System and promote the outstanding work we do here. Details will be shared once airing dates are confirmed.

- The Circle of Life comprised of inlaid stonework which greets patients and families in the lobby of the Gene Upshaw Memorial Tahoe Forest Cancer Center, has been completely re-painted and every space filled. We have been assured that future cleaning maintenance policies are in place to ensure engravings will be visible in perpetuity. Proceeds benefit the Community for Cancer Care Endowment. www.endowment4cancercare.com

- Grateful Patient: The Foundation continually receives heartfelt testimonials from patients about their positive experiences at Tahoe Forest Health System. We have the honor of bestowing orange Guardian Angel name badges to the staff, physicians, nurses, & caregivers who receive accolades from grateful patients and family members. In order to capture more donations/testimonials from patients, the Foundation is exploring cost of proving a small "amenity kit" to all in-patients that would include a Grateful Patient card and note from the Foundation.

- Foundation Staff Updates: Carissa Binkley is taking on an added responsibility to her current duties and will serve as the lead for Grant Administration/Coordination. She will work with various departments to identify grant opportunities with the goal of increased revenue for the Health System. Carey Hood will split her time between Foundation projects and community development outreach projects. We were fortunate to have an un-paid summer intern this year who was an enormous help with day-to-day tasks, and are hoping to bring on another intern this fall. We have also hired a short-hour Gift Tree Manager that brings a wealth of knowledge to retail management, volunteer management and most importantly, creative ways to increase revenue!

- Foundation staff is encouraged to seek educational opportunities as a way to increase our knowledge and improve our performance as it relates to our jobs. I have been participating in the UNR College of Extended Studies series through TFHD which have been very beneficial. I also plan to attend the Association of Healthcare Philanthropy International Conference in Chicago this October.

- Finally, I am very pleased to announce that our Foundation Board is expanding to include new members that provide a diverse representation of our community. We look forward to providing continued philanthropic revenue to support our Health System!

Mark your Calendar:

Tahoe Forest Health System Open House: Thursday, October 6, 2016
Artisan Fair in lobby of Tahoe Forest Hospital sponsored by The Gift Tree: Thursday, December 8, 2016
National Doctor's Day: March 30, 2017 (stay-tuned for details on how the Foundation plans to Honor Physicians)
Best of Tahoe Chefs, Sunday, May 21, 2017
Gene Upshaw Memorial Golf Classic, July 9 & 10, 2017

TAHOE FOREST HEALTH SYSTEM FOUNDATION

Date: September 13, 2016

To: Tahoe Forest Hospital District Board of Directors

From: Martha Simon, Director – Tahoe Forest Health System Foundation (TFHSF) and Foundation Board Nominating Committee

Re: Request to ratify new TFHSF Board Candidates

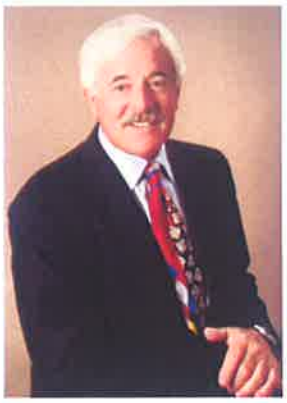
Dear Tahoe Forest Hospital District:

At the May 11, 2016 meeting of the TFHSF Board of Directors, the board agreed to vote on a slate of new candidates, nominations and the seating of the Foundation Board.

The Board approved these nominations on 9/12/16. These candidates will maintain the membership of the Foundation Board of no less than 6 voting members and 1 ex-officio non-voting member. Full Bio's of each attached.

1. Jon Shanser, M.D., *Physician executive with experience as both a clinician and medical director*
2. Randy Sater, *President Stonebridge Properties, a subsidiary of Teichert Land Co.*
3. Mary Brown, *former board chair for Sutter Health-affiliated Alta Bates Summit Medical Center in Oakland and Berkeley*
4. Jack McHugh, *Financial Consultant working at 1st Discount Brokerage, Inc. in Half Moon Bay, CA and has over 33 years of experience in the finance industry.*
5. Sarah Bormann, *CEO of Tahoe University*
6. Lisa Peltier, *Vice President of operations and a senior consultant for BSM Consulting*
7. Cheryl Luther, *Realtor with Chase International*

Respectfully submitted on behalf of the TFHSF Nominating Committee (Chris Ryman, Trinkie Watson, Martha Simon)



Jon Shanser, M.D.

Jon Shanser is a physician executive with experience as both a clinician and medical director.

Dr. Shanser has a broad understanding of healthcare's evolving economic context and has experience in medical coding and billing as well as regulatory compliance. He currently is medical director of clinical services for one of the major specialty benefits management companies(HealthHelp), and has served as radiology departmental leader and long time medical executive committee member for Saint Francis Hospital in San Francisco. He has published numerous scientific articles, has presented at various scientific conferences, and is active in several professional organizations. He has been on the Council Steering Committee for the American College of Radiology and has served as President of the California Radiological Society where he remains on its Executive Committee.

Dr. Shanser completed a fellowship in genitourinary and interventional radiology and a residency in diagnostic radiology both at UCSF Medical Center in San Francisco. He is Board Certified in Diagnostic Radiology, and licensed in California and Nevada.

STONEBRIDGE
PROPERTIES, LLC

Randy Sater
President, StoneBridge Properties, LLC

Randy Sater has over twenty-five years of experience in Real Estate, Land Use Planning and Community Building. He serves as President of StoneBridge Properties, LLC. StoneBridge Properties, a subsidiary of Teichert Land Co., is a developer of sustainable masterplanned communities. Randy's community involvement includes 2016 Board Member for The Crocker Art Museum, 2013 Board Chair for the Power Inn Alliance Business Improvement District, 2010 Board Chair for the Sacramento Metropolitan Chamber of Commerce, Full Member and Past-Chair of the Urban Land Institute Sacramento, founding member and Past President of the Cache Creek Conservancy, Past Chair of Valley Vision, and Board Member of the California State University, Sacramento Advisory Board

Mary Brown

Ms. Brown, along with her husband Chip Brown, founded Hills Newspapers, Inc. At one time, they were responsible for the publication of 18 community newspapers and magazines in the East Bay, Monterey Peninsula and San Joaquin Valley areas.

Ms. Brown has spent over 20 years on the boards of hospitals and health care systems. She has been a trustee for Sutter Health in Northern California, Alta Bates/Summit Hospital in Oakland and Berkeley and Providence Hospital in Oakland. She has also served on the governing boards of numerous other civic, academic and corporate entities including Oakland Public Library Foundation, Samuel Merritt University and Holy Names University. Ms. Brown attended Maryville College of the Sacred Heart in St. Louis and the San Francisco College for Women.

Mary along with her husband Chip are now permanent residents in Truckee enjoying living in the same community as their children and grandchildren.

John D. (Jack) McHugh II

John D. McHugh II "Jack" is a Financial Consultant affiliated with 1st Discount Brokerage headquartered in Florida. Prior to going to college, Jack served in the military attached to the 82nd Army Airborne Division. He holds an undergrad and graduate degree from American International College.

Jack brings thirty plus years of financial expertise to the numerous non-profit Boards in which he sits. He was a member of the Boys & Girls Club Board for over 10 years and continues to be the Finance Chair. He has served as President of the Johnston House Foundation (Historical landmark house and property) and has been instrumental in its completions. Jack served on the foundation Board of Seton Medical Center for several years, last serving as Vice-Chair of the hospital foundation board. He also services on the finance committee of Senior Coastsider's of Half Moon Bay, and advisor to Coastside Adult Day Health. Another non-profit close to his heard is the American Diabetes Association for which he has been an avid fundraiser and organizer.

Jack has been a resident of Ocean Colony in Half Moon Bay for 22 years which his wife, Charise and three children. He now has 6 grandchildren. He moved his business from the San Francisco Financial District to Half Moon Bay in 1990 to enjoy living and working in the small town community where serving non-profits is so rewarding Jack and Charise have also maintained their second residence in Truckee for over 27 years.

Sarah Bormann

Sarah is passionate about experiencing everything that Tahoe has to offer with her family and friends. She is married to her high school sweetheart Adam and is the proud mother of two young boys. Sarah deeply committed herself to the Tahoe lifestyle after confronting serious personal adversity, and today Sarah along with cousins Erin and Marne founded Tahoe University. They created a retail experience that carries a unique assortment of one of a kind lifestyle items to complement your Tahoe story from apparel, furniture and home goods, located in Truckee's historic Star Hotel. Strong and meaningful relationships bring her joy, and Sarah is passionate about making every moment count and about working hard to better the lives of others.

Sarah brings years of strong business management and leadership experience across a diverse set of disciplines, including the customer service and consumer industry. She has been an entrepreneur since a very young age when she helped to manage her family's consumer chain of restaurants. Sarah's parents were entrepreneurs, and from them she found her love of connecting with and learning from customers. Sarah has worked for several corporations, and she has strong financial management skills; experience recruiting and motivating talented team members; experience working with vendors and other outside partners to achieve shared results; and real estate and other corporate management experience.

Lisa Peltier

Vice President, Operations
BSM Consulting

Lisa Peltier is vice president of operations and a senior consultant for BSM Consulting. Ms. Peltier has extensive consulting skills in finance, including practice valuations, new business proforma/forecasting, financial benchmarking and trend analysis, development of practice budgets, and financial matters. She also is skilled in general practice management issues such as human resources, personnel training and development, and staff management issues.

Additionally, she is responsible for coordination of services provided by various BSM consultants, optimally matching client needs with appropriate BSM resources. She coordinates activities involving multiple consultants and maintains general oversight responsibility to ensure the quality and timely completion of projects.

Ms. Peltier has authored various articles on practice financial matters and staff management. She has provided lectures for numerous medical societies and national conventions.

Ms. Peltier has more than 29 years of medical consulting experience with BSM. Before joining the company, she managed a financial consulting firm and worked for General Electric for 12 in sales and customer service supervision.

Ms. Peltier is a member of the BSM Executive Management team. She works at the BSM headquarters office located in Incline Village, NV, where she and her family have lived for 27 years. She is a graduate of Sawyer College of Business in Pasadena, CA. Her outside interests include hiking, golf, gardening, cooking, and travel. Ms. Peltier is a member of the Pastoral Council at St. Francis of Assisi Catholic Church in Incline Village and enjoys doing volunteer work at church and with other groups.

BSM | Consulting

Cheryl Luther

Born and raised in Northern Arizona, Cheryl brings to her work team an experienced back ground in customer service, executive office skills and property management. After graduating, Cheryl worked at Denali National Park, Alaska, meeting like-minded individuals who came to Tahoe for skiing and boating.

Back in the lower 48's, Cheryl was the operating manager for Ski West Vacation Rentals & Realty for six years. This gave her an upper hand when transferring to her Real Estate career. Currently Cheryl is the marketing coordinator and transaction officer for Chase Realtor, Trinkie Watson, as well as a licensed Real Estate agent. Cheryl is tech savvy, up on trends and statistics and has a wealth of knowledge.

When not indulging in Real Estate she is the President of the Alder Creek Middle School Parent Teacher Organization and the Scholastic and Fundraising Coordinator for the Truckee Youth Pop Warner Football and Cheerleaders. Cheryl is also an Ambassador for the Truckee Chamber of Commerce and an advocate for the Kid Zone Museum.

Being involved with her two children, spending time with her husband, bike riding, hiking, and downhill snowboarding along with participating in other outdoor events are what keep her going with a positive attitude and outlook on life! Cheryl is always willing to go the extra mile for clients, friends, co-workers and family.

DRAFT

TAHOE FOREST HOSPITAL DISTRICT (CAH)
INCLINE VILLAGE COMMUNITY HOSPITAL (CAH)

MEDICAL STAFF BYLAWS

~~2015~~2016

DRAFT Bylaws Review: [06092016]
Legal review: 07122016
Recommended by MEC: 7/21/16

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TAHOE FOREST HOSPITAL DISTRICT
MEDICAL STAFF BYLAWS

PREAMBLE

These Bylaws are adopted In recognition of the mutual accountability, interdependence, and responsibility of the Medical Staff and the Board of Directors of Tahoe Forest Hospital District which include Tahoe Forest Hospital and Incline Village Community Hospital; both are Critical Access Hospitals in protecting the quality of medical care provided in the Hospital and assuring the competency of the Hospital's Medical Staff. The Bylaws provide a framework for self government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, including but not limited to structuring itself to provide a uniform standard of quality patient care, treatment and services; to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes; and to account to the Board of Directors for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities, including but not limited to, periodic meetings of the Medical Staff, its committees, and departments and review and analysis of patient medical records; they describe the standards and procedures for selecting and revoking Medical Staff officers; and address the respective rights and responsibilities of the Medical Staff and the Board of Directors.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Board of Directors must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Board of Directors commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Board of Directors will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

Each member of the Medical Staff shall abide by the Medical Staff Bylaws and Rules and lawful standards and policies of the Medical Staff and the Hospital, including, but not limited to, any applicable Medical Staff and/or Hospital policies respecting unlawful harassment and Practitioner conduct.

DEFINITIONS

1. HOSPITAL means Tahoe Forest Hospital and Incline Village Community Hospital.

2. BOARD OF DIRECTORS means the Board of Directors of the Hospital, and may include a committee or individual authorized by the Board of Directors to act on its behalf.

3. CHIEF EXECUTIVE OFFICER means that individual appointed as Chief Executive Officer of the Hospital by the Board of Directors to act on its behalf in the overall management of the Hospital.

4. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O.), dentists, and podiatrists who have been appointed to the Medical Staff pursuant to the terms of these Bylaws.

5. MEDICAL EXECUTIVE COMMITTEE means the Medical Executive Committee of the Medical Staff.

6. PHYSICIAN means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

7. DENTIST means an individual with a D.D.S. or D.M.D. degree who is currently licensed to practice dentistry. It shall include oral surgeons.

8. PODIATRIST means an individual with a D.P.M. degree who is currently licensed to practice podiatric medicine.

9. PRACTITIONER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist, or Allied Health Professional holding a current license to practice who may or may not be a member of the Medical Staff.

10. MEMBER means a practitioner who is a member of the Medical Staff.

11. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to Medical Staff members or allied health professionals to provide patient care within the facilities of the Hospital.

12. MEDICAL STAFF YEAR means the period from January 1 through December 31.

13. CHIEF OF STAFF means the chief officer of the Medical Staff selected pursuant to these Bylaws.

14. AUTHORIZED REPRESENTATIVE or Hospital's Authorized Representative means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

15. EMERGENCIES are defined as "an acute life threatening situation or acute sensory or limb threatening situation".

16. URGENT CASES are defined as "sub-acute situations where undue delay will produce Irreversible damage".

17. TELEMEDICINE is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

18. INELIGIBLE PERSON means any person who is currently excluded, suspended, debarred, or ineligible to participate in any federal health care program, or has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

ARTICLE I

NAME

The name of this organization is the Medical Staff of Tahoe Forest Hospital District.

ARTICLE II

MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No physician, dentist, or podiatrist, including those in a medical-administrative position by virtue of an agreement with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he/she is a member of the Medical Staff enjoying corresponding privileges or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws and the Rules. Appointment to the Medical Staff shall confer only those privileges and prerogatives, which have been granted in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

A practitioner must demonstrate compliance with all the basic standards set forth in this section in order to qualify for Medical Staff membership. To meet the basic qualifications for membership, all applicants must:

a. Demonstrate and maintain their experience, ability (including mental and physical fitness, with or without reasonable accommodations, to perform the functions associated with requested privileges), and current competence to exercise the privileges they wish to hold. These general standards shall require proficiency in all of the following areas:

   1) Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and/or injury, and care at the end of life, as applicable to their specialties.

   2) Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

3) Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.

4) Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team.

5) Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.

6) Systems-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

b. Document their current licensure as required by law.

c. Demonstrate that they are willing to participate in and properly discharge those responsibilities determined according to these Bylaws;

d. Not be ineligible to participate in federally-funded health care programs, and not become ineligible during any term of membership;

e. Provide ongoing verification of medical malpractice insurance coverage meeting the requirements of these Bylaws in the amount of $1,000,000 and $3,000,000; and

f. If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that has the contract.

2.2-2 PARTICULAR QUALIFICATIONS

a. Physicians: An applicant for physician membership in the Medical Staff must hold a valid license to practice medicine issued by the Medical Board or Board of Osteopathic Examiners in (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

b. Dentists, Oral Surgeons, and Podiatrists

(1) Dentists and Oral Surgeons: An applicant for dental membership in the Medical Staff must hold a valid license to practice dentistry issued by the Board of Dental Examiners (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

(2) Podiatrists: An applicant for podiatric membership on the Medical Staff must hold a valid license to practice podiatry issued by the appropriate licensing board (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

2.3 EFFECT OF OTHER AFFILIATIONS

(a) No person shall be entitled to membership in the Medical Staff, assignment to a particular staff category, or the granting or renewal of particular clinical privileges merely because that person:

(1) holds a certain degree;
(2) is licensed to practice in California, Nevada, or any other state;
(3) is a member of any particular professional organization;
(4) is certified by any particular specialty board;
(5) had, or presently has, membership or privileges at this or any other health care facility; or
(6) requires a hospital affiliation in order to participate on health plan provider panels, to obtain or maintain malpractice insurance coverage, or to pursue other personal or professional business interests unrelated to the treatment of patients at this facility and the furtherance of this facility's programs and services.

(b) A revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board or health care facility regarding a practitioner's license, certificate, membership or clinical privileges, whether contested or voluntarily accepted, shall constitute grounds for an unfavorable credentialing or peer review action by this Medical Staff. The Medical Staff shall consider the nature and gravity of the charges or allegations and the resulting disciplinary or corrective action, but shall not be obligated to conduct evidentiary proceedings regarding events that occurred elsewhere.

2.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or clinical privileges shall be determined on the basis of color, national origin, gender, religion or creed, marital status, age, sexual preference, or disability including AIDS and related conditions.

2.5 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

(a) A practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the Medical Staff.

(b) A practitioner contracting with the Hospital in an administrative capacity with clinical duties or privileges must be a member of the Medical Staff, achieving his/her status by the normal application and appointment procedures described in these Bylaws.

(c) Unless a contract or agreement executed after the adoption of this provision provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the fair hearing procedures of Article VII of these Bylaws, upon termination or expiration of such practitioner's contract or agreement with the Hospital. Furthermore, if the practitioner's privileges are limited to those subject to the exclusive or semi-exclusive arrangement, Medical Staff membership shall also terminate without the right of access to the fair hearing procedures of Article VII of these Bylaws.

(d) Contracts between practitioners and the Hospital shall prevail over these Bylaws; except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the National Practitioner Data Bank.

(e) Practitioners who subcontract with practitioners who contract with the Hospital will automatically forfeit (without the right of access to the fair hearing procedures of Article VII of these Bylaws) any privileges that are subject to an exclusive or semi-exclusive arrangement if their relationship with the contracting practitioner is terminated. Furthermore, if the practitioner's privileges are limited to those subject to the exclusive or semi-exclusive arrangement, Medical Staff membership shall also terminate without the right of access to the fair hearing procedures of Article VII of these Bylaws. The Hospital may enforce such automatic termination even if the subcontractor's agreement fails to specifically recognize this right.

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The responsibilities of each member of the Medical Staff and of any practitioner holding temporary clinical privileges are to:

(a) provide patients with the high quality of care, which meets the professional standards of the Medical Staff and the Hospital;

(b) abide by the Medical Staff Bylaws, Medical Staff Rules, Medical Staff and Departmental policies, and Hospital policies that relate to patient care and safety;

(c) discharge in a responsible and cooperative manner, those responsibilities which are assigned by virtue of Medical Staff membership, category, assignment, election, or otherwise, including committee assignments and other credentialing, peer review, and quality assessment and performance improvement duties;

(d) prepare and complete in timely fashion medical and other required records for all the patients to whom the member provides care in the Hospital;

(e) abide by the ethical principles of the appropriate state medical or other professional association(s), and, as applicable, the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Osteopathic Association, and the Code of Ethics of the American Podiatry Association;

(f) work with and relate to other staff members, members of other health disciplines, Hospital management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner so as to create and maintain a working environment conducive to quality and efficient patient care;

(g) make appropriate arrangements for coverage for his/her patients as determined by the Medical Staff, refrain from delegating the responsibility for diagnosis or care of hospitalized patients to any practitioner who lacks the qualifications or privileges to undertake this responsibility, and seek appropriate consultations when indicated;

(h) refuse to engage in division of fees, under any guise whatsoever, or any other improper inducements for patient referral;

(i) participate in continuing education programs;

(j) upon request, provide information from his/her office records as necessary to facilitate the care of or review of the care of specific patients;

(k) participate in such emergency service coverage or consultant panels as may be established by appropriate committees and officials of the Medical Staff;

(l) discharge such other obligations as may be lawfully established from time to time;

(m) notify the Department chairperson or the Chief of Staff in the event the member or practitioner develops a physical, mental, or emotional disability that would significantly interfere with his/her medical practice;

(n) continuously meet the qualifications for membership as set forth in these Bylaws. (It is understood that a member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws and the Rules whenever the Medical Executive Committee has good cause to question whether the member continues to meet such requirement);

(o) protect and preserve the confidentiality of patient health or payment information, including compliance with applicable confidentiality laws and with the confidentiality policies and rules of the Hospital and Medical Staff concerning the use and disclosure of patient health information and records;

(p) provide the Medical Staff Office with a complete and current mailing address and accept Certified or Registered Mail from the Medical Staff;

(q) promptly notify the Medical Staff Office in writing of:

(1) the initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;

(2) an action by the medical staff executive committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

(3) the member's exclusion from participation in Medicare, Medi-Cal or any federal health care program or conviction of a criminal offense related to the provision of health care items or services;

(4) any formal allegations of fraud or abuse or illegal activity relating to a member's professional practice or conduct made by any State or Federal government agency;

(5) any report filed with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank,

(6) the filing of any malpractice claim or action in which the Practitioner is a named defendant; or

(7) any other action that could affect his/her Medical Staff standing and/or clinical privileges at the Hospital.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Courtesy and Honorary. At each time of reappointment, the member's Medical Staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff shall consist of members who:

a. meet the general qualifications for membership set forth in Section 2.2 of the Bylaws;

b. have satisfactorily completed the provisional requirements for new staff as described in Section 4.7;

(1) Until completion of such requirements, they shall be referred to as Provisional Active. References in these bylaws to "Active Staff" shall not be deemed to include members of the Provisional Active Staff unless the intent to include Provisional members is clear.

c. have primary offices and residences in the Truckee/Incline Village area which are located closely enough to the hospital to allow for appropriate continuity of care;

d. regularly admit and care for inpatients and outpatients in the Hospital and are regularly involved in Medical Staff activities, including attendance at Department meetings; and

e. provide specialty call back-up and consultation as may be required by the Rules and Regulations.

3.2-2 PREROGATIVES

Except as otherwise provided the prerogatives of an Active Staff member shall be to:

a. admit patients and exercise such privileges as are granted pursuant to the Bylaws and the Rules and Regulations;

b. attend and vote on matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member;

c. hold Medical Staff and Department office and serve as chairman and/or a voting member of committees to which he/she is duly appointed or elected by the Medical Staff or duly authorized representative thereof;

d. be assigned to an appropriate Medical Staff department based upon clinical practice;

e. elect not to be included on the call schedule if they have been an Active Member for the past fifteen (15) years and who are aged 55 or more.

Provisional Active members may not vote or hold office or chairmanship until they have completed their provisional requirements as described in Section 4.7.

3.3 COURTESY STAFF

3.3-1 QUALIFICATIONS

A physician or dentist may be eligible for Courtesy Staff membership if he/she is an active staff member at his/her primary hospital, and if he/she plans to make significant use of Tahoe Forest Hospital and/or Incline Village Community Hospital's hospital services. When loss of membership at his/her primary hospital occurs, the practitioner shall automatically lose his membership and privileges at Tahoe Forest Hospital and/or Incline Village Community Hospital.

The Courtesy Staff Shall Consist Of Members:

a. ~~whose primary practice is not in the Truckee/Incline Village area or, if their primacy practice is in the Truckee/Incline Village area, have been approved for Courtesy Staff membership for the current term by the Medical Executive Committee~~ who can demonstrate current competence and the maintenance of their knowledge and skills by documenting that they have routinely practiced in this or another acute care hospital, or another setting similarly calling for the exercise of their professional knowledge and skills, over the last twenty-four (24) months.

b. who meet the general qualifications set forth in Section 2.2 of the Bylaws; and,

~~who must be available within one hour's drive of the hospital if they have on-call responsibilities for the emergency department;~~

c. Specific clinical privileges shall be applied for and restricted in the same manner as privileges of Active Staff members. At the time of appointment and every two years at the time of reappointment, a practitioner shall provide documentation

from his/her primary hospital. In the case of inpatients, the Courtesy Staff member shall find an appropriate active staff member who agrees to attend patients in case of an emergency where distance makes it impossible for the Courtesy Staff member to be at the patient's bedside in a reasonable time.

3.3-2 PREROGATIVES

Except as otherwise provided, the Courtesy Staff member: ~~shall be entitled to~~:

a. shall be entitled to admit patients and exercise such privileges as are granted pursuant to these Bylaws and the rules and regulations;

b. shall provide for continuous care of his/her patients;

~~a.~~c. shall be entitled to attend in a non-voting capacity meetings of the Medical Staff and the department and committees of which he/she is a member, but shall not have the right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment; ~~and~~

~~b.~~d. shall be assigned to an appropriate medical staff department based on clinical practice, but shall be ineligible to hold medical staff office; and,

e. ~~courtesy staff members shall not be eligible to hold medical staff office~~must pay application fees, dues and assessments to the medical staff.

3.2~~3~~-3 TRANSFER TO ACTIVE STATUS:

Involvement in the care of greater than fifty (50) patients in a two (2) year period shall result in a transfer of the physician to the Active Staff. The applicant may petition the MEC for an exception. Consideration for exceptions may be given by the MEC on a case-by-case basis. Examples for consideration of an exception may include physician's working as hospitalists, emergency medicine, radiology, or pathology.~~.~~

3.4 HONORARY STAFF

3.4-1 QUALIFICATIONS

The Honorary Staff shall consist of physicians, dentists, and podiatrists who do not practice at the Hospital, and who might not reside in the community, but are deemed deserving of membership by virtue of their outstanding reputation, and/or their previous service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct. Such individuals must be nominated by the Medical Executive Committee and/or clinical department and approved by the Board.

3.4-2 PREROGATIVES

Honorary Staff members are not eligible to admit or care for patients in the Hospital or to exercise privileges in the Hospital, or to vote or hold office in the Medical Staff. They may

serve on Medical Staff committees, with or without vote, only at the discretion of the Medical Executive Committee. They may attend Medical Staff and Department meetings.

3.5 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership by other sections of the Bylaws and these Rules.

3.6 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, eligible podiatrists and dentists shall exercise admitting and clinical privileges only within the scope of their licensure and as set forth in Article V of these Bylaws.

3.7 MODIFICATION OF MEMBERSHIP

(a) On its own initiation or pursuant to a request by a member, the Medical Executive Committee may recommend a change in the Medical Staff status of a member consistent with the provisions of the Bylaws. Unless the change has been requested by the practitioner, the Medical Executive Committee shall afford the practitioner an opportunity to comment either in writing or in person before its recommendation is finalized and forwarded to the Board of Directors. There shall be no right to a Hearing under Article VII except as expressly provided therein or required by law.

(b) After two consecutive years in which a member of the Active Staff fails to regularly care for patients in the Hospital as required by that staff category, that member may be automatically transferred by the Medical Executive Committee to the appropriate Medical Staff category, if any, for which the member is qualified.

(c) Action may be initiated to evaluate and possibly terminate the privileges and membership of any staff member (except Honorary) who has failed to have any activity within the Hospital during the previous two years.

3.8 RESIDENT MEDICAL STAFF

3.8-1 QUALIFICATIONS

Resident medical staff membership shall be held by post-doctoral trainees (residents and fellows) in training programs of teaching institutions who are not eligible for another staff category and who are either licensed or registered with the appropriate State of California/Nevada licensing board. All resident medical staff members must obtain a license to practice medicine within the State of California/Nevada when eligible.

3.8-2 APPOINTMENT

a. Post-doctoral trainees who are enrolled in accredited residency training programs, with whom TFHD has a Memorandum of Understanding (MOU), and who meet the above qualifications shall be appointed to the resident medical staff. Members of the resident staff are not eligible to hold office within the medical staff but may participate in the activities of the medical staff through membership on medical staff committees, with the right to vote within committees if specified at the time of appointment, and non-voting attendance at medical staff meetings.

b. All medical care provided b resident medical staff is under the supervision of members of the Active Staff. Such care shall be in accordance with the provisions of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation. Residents must be supervised by teaching staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability, and experience

c. Appointment to the resident medical staff shall be for one year and may be renewed annually. Resident medical staff membership may not be considered as the observational period required to be completed by provisional staff. Resident medical staff membership terminates with termination from the training program.

ARTICLE IV

APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person, including those in a medical-administrative position by virtue of a contract with the Hospital, shall exercise privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, the applicant agrees that during the credentialing process and throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the member only such privileges as have been granted in accordance with these Bylaws. ~~Appointment and Reappointment to the Medical Staff shall not become effective until payment of the Medical Staff dues is received, as specified by the Medical Staff in accordance with these Bylaws and the Rules.~~

4.2 QUALIFICATIONS FOR INITIAL APPOINTMENT

Threshold Eligibility Criteria for Initial Appointment:

To be eligible to apply for initial appointment to the Medical Staff, physicians, dentists, and oral surgeons must meet all of the following:

(a) where applicable to their practice, have a current, unrestricted DEA registration;

(b) be located close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital, including the Emergency Department, if applicable;

(c) have current, valid professional liability insurance coverage in amounts of $1 million/$3 million, or such other amount established by Board policy.

(d) are not currently excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(e) agree to fulfill all responsibilities regarding emergency call established by the medical staff;

(f) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;

(g) have successfully completed a residency training program and be certified or eligible by an American Board of Medical Specialties (ABMS) member board in the specialty in which the applicant seeks clinical privileges; or by the American Osteopathic Association (AOA) in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(h) be board certified or qualified to sit for the boards in their primary area of practice at the Hospital subject to the recertification provision, below. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship

training are required to become board certified within five (5) years of residency or fellowship training[1];

~~(a)~~(i) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements.[2] If a physician has not met the recertification requirements of his/her board for his primary specialty by the time the reappointment is required, the physician will have up to two (2) years from the date of his/her board's expiration to attain such recertification. If a physician does not meet the recertification requirements of his/her board by the end of this time, the physician shall not be eligible for reappointment;

An individual who does not meet the Medical Staff's board certification requirements may request a waiver. The individual requesting the waiver bears the burden of showing that:

(1) it would not be possible, with reasonable and good faith efforts, for him or her to become board certified, maintain board certification, or regain board certification, as applicable; and

(2) based on his or her qualifications, experience and demonstrated competence, he or she can be relied upon to provide care of the same quality and sophistication that is expected of those who have achieved initial board certified in the same specialty.

A request for a waiver must be submitted in writing to the Medical Executive Committee, and be accompanied by a written statement and relevant documentation in support if it. The MEC shall consider the request and make a recommendation to the Board. The MEC may give the practitioner an opportunity to make an oral presentation and respond to questions before formulating its recommendation. The denial of a waiver shall not entitle the practitioner to a hearing under Article VII of these Bylaws.

(j) demonstrate recent clinical activity in their primary area of practice by submitting a case list from the last two years.

[2] This provision shall only apply to physicians who were granted staff privileges on or after (Board approval date), the date of initial adoption by the Board of Directors.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information necessary ~~to an~~for a proper evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the privileges and Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to

[1] The provision requiring board certification shall only apply to those physicians who were granted hospital privileges on or after (Board approval date)___.

complete his/her application will be grounds for a refusal to take action on that application, which shall not be subject to appeal or review under Article VII of these Bylaws.

In order for the Medical Executive Committee to make a recommendation to the Board of Directors concerning an applicant for appointment or reappointment to the Medical Staff or additional clinical privileges, the Medical Staff must have in its possession adequate information for a conscientious evaluation of the applicant's training, experience and background as measured against the unique professional standards of this Hospital. Accordingly, the Medical Staff will not take action on an application that is not "complete."

4.2-1. COMPLETE APPLICATION FOR APPOINTMENT, REAPPOINTMENT, OR NEW PRIVILEGES

An application for appointment, reappointment or new clinical privileges shall not be deemed "complete," for purposes of subparagraph 4.2-3 below, until:

a. The applicant submits a written application, using the prescribed form, in which all of the requisite information is provided. All entries and attachments must be legible, understandable and substantively responsive on every point of inquiry.

b. The applicant responds to all further requests from the Medical Staff, through its authorized representative, for clarifying information or the submission of supplementary materials. This may include, but not necessarily be limited to, submission to a medical or psychiatric evaluation, at the applicant's expense, if deemed appropriate by the Medical Executive Committee to resolve questions about the applicant's fitness to perform the physical and/or mental functions associated with requested clinical privileges. If the requested items of information or materials, such as reports or memoranda, are in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain them or to arrange for them to be submitted to the Medical Staff directly by the source.

c. The applicant has assisted as necessary in the solicitation of written evaluations from those listed by the applicant as references and from other potential sources of relevant information. Such assistance may include the signing of a special release or similar document, as requested.

4.2-2 COMPLETE APPLICATION FOR NEW OR ADDITIONAL PRIVILEGES

An application for new or additional privileges by a member of the Medical Staff in good standing, for which there might or might not be a prescribed form, shall not be complete unless and until:

a. The applicant submits a written request for privileges, supported by a complete description of the applicant's training, experience and other qualifications for the requested privileges, with documentation as appropriate.

b. The applicant responds to requests for information and materials as described above.

4.2-3 INCOMPLETE APPLICATION

An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Notwithstanding any other provision of these Bylaws, an application that is determined to be incomplete shall not qualify for credentialing recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given a reasonable opportunity to do so, the credentialing process will be terminated, at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or at a meeting, as determined by the Medical Executive Committee. An incomplete application will not be processed.. Termination of the credentialing process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

4.2-4 APPLICANT RESPONSIBILITY FOR KEEPING APPLICATION CURRENT

Until notice is received from the Board of Directors regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing, of any material change in the information provided or new information that might reasonably have an effect on the applicant's candidacy, including the filing of any malpractice claim against the applicant. Failure to meet this responsibility shall be grounds for denial of the application, nullification of any approval if granted, and/or termination of Medical Staff Membership.

4.2-5 COMPLETED APPLICATION TIME PERIOD

A complete application shall be acted upon within a reasonable time period not to exceed 60 days except that action by the Board of Directors may be delayed for a good cause.

4.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, appointments to the Medical Staff shall be for a period of two years. Reappointments shall be for a period of up to two years.

4.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

An applicant for appointment and reappointment shall complete written application forms that request information regarding the applicant and document the applicant's agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws and Rules. Following its investigation, the Medical Executive Committee shall recommend to the Board of Directors whether to appoint, reappoint, and/or grant specific privileges.

4.5 BASIS FOR APPOINTMENT AND REAPPOINTMENT

Recommendations for appointment to the Medical Staff and for granting of privileges shall be based upon the applicant's training, experience and professional performance at this Hospital and in other settings, whether the applicant meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon the Hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner.

Evidence of the applicant's identity, character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current chiefs or chairmen at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

4.5-1. APPLICATION FORM

An application form shall be developed by the Hospital and the Medical Staff. The form shall require detailed information which shall include but not be limited to, information concerning:

a. the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, Nevada pharmacy certificate and fluoroscopy certificate as appropriate, professional affiliations, and continuing medical education information related to the privileges to be exercised by the applicant;

b. peer references (at least three), some of whom are in the same specialty, who have had extensive experience in practicing with, or otherwise observing, the applicant and who are therefore familiar with the applicant's current professional competence and ethical character; no more than one reference may be from a practitioner with whom the applicant is currently in practice or would be in practice upon obtaining membership;

c. requests for Medical Staff status, Department affiliation, and privileges;

d. any past or pending, voluntary or involuntary, professional disciplinary actions, licensure, DEA Permit, or Nevada certificate limitation; federal or state investigations, or related matters;

e. physical and mental status relative to the clinical privileges requested;

f. professional liability insurance coverage which shall be maintained in effect in limits set in accordance with these Bylaws;

g. a detailed description of any proposed or implemented restrictions or denial of licensure or governmental certification or registration;

h. a description of any suspension or termination of specialty board certification or eligibility;

i. a detailed description of any professional liability ~~suits or~~litigation experience, including past and pending claims, final judgments, or settlements; the substance of

the allegations as well as the findings and the ultimate disposition against the applicant ~~and the outcomes thereof~~;~~and~~ any additional information concerning such proceedings or actions as the Medical Executive Committee, or the Board of Directors may request; and

j. A current valid state or federal agency ~~picture ID~~photo identification card (passport or driver's license) or, at the discretion of the Medical Staff, a current valid Hospital picture ID card, in order to verify that the applicant is the same practitioner identified in the credentialing documents.

Each application for initial appointment to the Medical Staff shall be in writing, or electronically submitted on the prescribed form with all provisions completed, and signed by the applicant.

4.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1 of the Bylaws, by applying for appointment to the Medical Staff each applicant:

a. signifies his/her willingness to appear for interviews in regard to the application;

b. authorizes consultation with others who may have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes those individuals and organizations to candidly provide that information;

c. consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out the privileges and status requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

d. releases from any liability, to the fullest extent permitted by the law, all persons for their acts performed in connection with investigating and evaluating the applicant, all individuals and organizations who provide information regarding the applicant, including information otherwise deemed confidential;

e. consents to the disclosure, upon appropriate request, to other hospitals, medical associations, licensing boards, and to any other relevant organization, of any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for doing so to the fullest extent permitted by law;

f. acknowledges responsibility for timely payment of Medical Staff dues as specified by the Medical Staff in accordance with the Bylaws and these Rules;

g. pledges to provide for continuous quality care for patients;

h. pledges to maintain an ethical practice, including refraining from illegal inducements for patient referrals, providing continuous care of his/her patients, seeking consultation whenever indicated, refraining from providing illusory or unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

i. pledges to be bound by the Medical Staff Bylaws, Rules, and policies;

j. acknowledges that any omission or falsification of information may result in denial of an application;

k. consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee; and

l. signifies his/her willingness to abide by all the conditions of membership, as stated on the application form, the reapplication form, and in these Rules.

4.5-3 APPLICATION FEE

The applicant shall deliver a completed application to the Chief of Staff or his/her designee, a non-refundable application fee, and any dues per Medical Staff Policy.

4.5-4 VERIFICATION OF INFORMATION

The Chief of Staff and the Chief Executive Officer shall be notified of the application. The Medical Staff office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Hospital's Authorized Representative shall query the National Practitioner Data Bank, the appropriate state medical board(s), and other relevant sources, such as but not limited to the Federation of State of Medical Boards Physician Disciplinary Data Bank, regarding the applicant and include any resulting information in the applicant's credentials file. The Medical Staff Office shall also obtain such additional information or documentation as necessary to confirm that the individual requesting membership and privileges is the same individual identified in the credentialing documents. After the application is completed, the application and incidental credentialing materials shall be transmitted to the chair of each Department in which the applicant seeks privileges. The applicant shall be notified of any difficulties encountered in obtaining the information required, and it shall be the applicant's obligation to obtain the required information.

4.5-5 HEALTH INFORMATION

Information regarding the applicant's health status shall be immediately transferred to the custody of the Well-Being Committee, and shall not be considered by the Medical

Executive Committee until after the applicant has otherwise been determined to qualify for membership.

4.6 ACTION ON THE APPLICATION

4.6-1 DEPARTMENT ACTION

After receipt of the application, the Department to which the application has been submitted shall review the application and the incidental credentialing materials. This review shall be conducted by the chairperson of the Department with the optional assistance of an ad hoc committee of members of the Department. That ad hoc committee is to be selected by the chairperson and membership shall be open to all members of the Department who are interested in contributing to the credentialing process. As part of this process, the applicant may be required to attend a personal interview with a representative of the Department. The chairperson of the Department shall then transmit to the Medical Executive Committee a written report and recommendation of the Department as to appointment and, if appointment is recommended, concerning the applicant's qualifications for the request for clinical privileges, applicant's character, professional competency, prior behavior and ethical standing and whether the applicant has established and satisfied all of the necessary qualifications for appointment. Included in the report shall be recommendation as to membership category, Department affiliation, privileges to be granted and any special conditions to be attached.

If the chairperson of the Department is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise considered incomplete under Section 4.2, the chairperson may delay further processing of the application, or may begin processing the application based only on the available information with an indication that further information may be considered upon receipt (this latter section referring only to particular clinical privileges requested that cannot be acted upon until requested documentation or other information is received). If the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the application shall be considered incomplete under Section 4.2 and the affected practitioner shall be so informed. Such an applicant's application may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.

4.6-2 MEDICAL EXECUTIVE COMMITTEE ACTION

After receipt of the Departmental report and recommendation, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Department for further review, and/or elect to interview the applicant. As part of making its recommendation, in the manner and to the extent permitted by law, the Medical Executive Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Medical Executive Committee**.** The Medical Executive Committee shall then formulate a preliminary recommendation. If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant's health status, including any reports of the Well-Being Committee, and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical

Staff. The Medical Executive Committee shall then finalize a recommendation regarding the application**.** The Medical Executive Committee may also defer action on the application but not indefinitely and shall be addressed at the next regularly scheduled meeting. The reasons for each recommendation should be stated.

4.6-3 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

a. **Favorable Recommendation.** Favorable recommendations shall be promptly forwarded to the Board of Directors together with the supporting documentation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

b. **Adverse Recommendation.** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the applicant, and he/she shall be entitled to the procedural rights as provided in Article VII of the Bylaws. The Board of Directors shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

4.6-4 BOARD OF DIRECTORS ACTION

a. **On Favorable Medical Executive Committee Recommendation.** The Board of Directors shall adopt, reject, or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond.

b. If the board is inclined to reject or modify a favorable recommendation, the Board shall refer the matter back to the Medical Executive Committee for further review and comments, which may include a second recommendation**.** The Executive Committee's response shall be considered by the Board before adopting a resolution.

~~b.~~c. If the Board's resolution ~~action is a~~ constitutes grounds for a hearing under Article VII of the Bylaws, the Chief Executive Officer shall promptly inform the applicant, and he/she shall be entitled to the procedural rights as provided in that Article.

~~c. **Without Benefit of Medical Executive Recommendation.** If the Board of Directors does not receive a Medical Executive Committee recommendation within a reasonable period of time after receipt of a completed application, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Board of Directors. If the recommendation is a ground for a hearing under the Bylaws, the Chief Executive Officer shall give the applicant notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the procedural rights described in Article VII of the Bylaws before any final adverse action is taken.~~

d. **After Procedural Rights.** In the case of an adverse Medical Executive Committee recommendation pursuant to Section 4.6-3 (b) or an adverse Board decision pursuant to Sections 4.6-4 (a) or (b), the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights under the Bylaws. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Board of Directors shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Board shall make a final decision.

e. **Conflict Resolution.** The Board of Directors shall give great weight to the actions and recommendations of the Medical Executive Committee and in no event shall act in an arbitrary and capricious manner.

f. The Governing Body may delegate decision-making authority to a committee of the Governing Body; however, any final decision of the Governing Body committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting.

4.6-5 NOTICE OF FINAL DECISION

a. Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee, the applicant, and the Chief Executive Officer.

b. A notice of decision to appoint or reappoint shall include, if applicable: (1) the Medical Staff category to which the applicant is appointed; (2) the Department to which that person is assigned; (3) the privileges granted; and (4) any special conditions attached.

4.6-6 TIMELY PROCESSING OF APPLICATIONS

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. ~~Within 60 days after receipt of the completed application, the application shall be considered by all persons and committees involved in the credentialing process.~~ This time period is provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within this specific time period.

4.7 ~~PROCTORING~~PROVISIONAL STATUS

4.7-1 OBSERVATION OF PROVISIONAL STAFF MEMBERS

a. Each new member of the Medical Staff shall be observed, or proctored, by one or more appropriate member(s) of the Active or Courtesy Staff per Medical Staff Policy. The proctor shall monitor the practitioner's performance and evaluate the member's (1) proficiency in the exercise of privileges initially granted and (2) overall eligibility

for continued Medical Staff membership and clinical privileges and advancement within Medical Staff Categories.

b. Proctoring will be reported on forms setting forth criteria to be used by proctors in evaluating performance. Included in the criteria to be evaluated shall be professional skill and judgment, cooperation with other professionals and Hospital staff, timely and thorough completion of medical records, and ethical conduct. Observation shall include those mechanisms customarily used to evaluate a practitioner's initial performance including, but not necessarily limited to, concurrent chart review, retrospective chart review, discussion, and proctoring by direct visual observation. The respective obligations of the observer and the practitioner being observed may be established in more detail through department clinical privileges criteria description, department rules, and/or medical staff policies. Although flexibility in the proctoring process is to be stressed, policy guidelines should require the timely completion of written evaluation forms.

c. A proctor may intervene in the care of a patient only if he or she believes that an error is being made that either may be life-threatening or that may result in permanent harm. In such circumstances, the proctored physician must step aside and/or follow the proctor's orders.

d. Proctoring may be concurrent or retrospective depending upon the nature of the privileges requested. A department may utilize an external proctor who is not a member of the Medical Staff if it is necessary to monitor a physician in a procedure not currently being done by other physicians on the staff. Medical Staff policies will define the process for proctoring by a practitioner not on the Medical Staff.

e. In the event of an unsatisfactory proctoring report, the practitioner being proctored shall be notified and shall be afforded an opportunity to have an informal conference with his/her Department chair concerning such report, provided, however, such opportunity shall not include access by the practitioner being proctored to written proctoring reports which shall be maintained as part of the peer review activities of the Medical Staff and shall be kept in strictest confidence unless or until such reports are used to deny or restrict privileges; then they shall be made available to the proctored physician.

f. Proctoring of practitioners with temporary privileges shall be performed pursuant to Section 5.4-3.

4.7-2 DURATION OF PROVISIONAL STATUS

a. All initial appointments to the Medical Staff shall be provisional for a period of no less than six (6) months and no more than ~~eighteen (18)~~ twenty-four (24) months as provided for in these bylaws, and new appointments and/or practitioners granted new privileges shall be subject to proctoring in accordance with standards and procedures set forth in these bylaws. If, at the end of ~~eighteen (18)~~ twenty-four (24) months, the practitioner has not satisfied the requirements for advancement to full

Active or Courtesy Staff for unsupervised privileges, the Medical Executive Committee ~~shall~~ may recommend to the Board of Directors that membership and privileges not be extended beyond the expiration of the current term of appointment. However, if during this provisional period, a staff member has met the ethical requirements for continued membership and has otherwise discharged all assigned obligations, but, for reasons beyond his control (e.g., practice seldom requires a hospital utilization), he has not been proctored or observed sufficiently to accommodate an evaluation of current competence for all of the requested clinical privileges, he may be granted a six (6) month extension of the provisional membership.

b. Advancement to the full Courtesy or Active Staff may be granted with some privileges remaining under proctorship as recommended by the Medical Executive Committee should the provisional privileges not be utilized.

c. A lapse of membership or clinical privileges by reason of the expiration of the maximum term of this provisional period shall not give rise to formal hearing rights, unless it is under circumstances which require a report to the Medical Boards of California or Nevada, Osteopathic Medical Boards of California or Nevada or the National Practitioner Data Bank, or the dental or podiatric boards of either California or Nevada.

d. Members of the provisional staff are required to ~~complete the reappointment process no later than two years from the date of their initial appointment~~ fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities..

e. In addition, members may be required to be proctored as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competence in that area).

Proctoring may also be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information-gathering measure. Therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. Proctoring does not give rise to the procedural rights described in Article VII of these Bylaws unless the proctoring has the effect of restricting a practitioner's privileges because the proctoring is imposed for reasons other than assessment of new or infrequently performed privileges and carries the condition that procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor.

~~e.~~f. The practitioner shall remain subject to such proctoring until the Medical Executive Committee has been furnished with a report signed by the chair of the Department to which the member is assigned describing: (i) that competencies are met and no further proctoring is necessary; (ii) the types and numbers of cases observed and the

evaluation of the applicant's performance; (iii) a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that Department, with any exceptions noted, has discharged all of the responsibilities of membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made, and (iv) any adverse information or recommendation based on review of the proctoring reports with follow up as described in 4.7-2**.** In all cases, the Medical Executive Committee shall make its recommendation to the Board of Directors regarding approval**,** modification or termination of privileges and Medical Staff membership.

4.8 REAPPOINTMENT

Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's performance at this Hospital and in other settings. The reappraisal is to include confirmation of adherences to the Medical Staff membership requirements as stated in these Bylaws, the Medical Staff Rules, the Medical Staff and Hospital policies, and the applicable department rules. Such reappraisal should also include relevant practitioner-specific information from performance improvement activities and where appropriate comparisons to aggregate information about performance, judgment and clinical technical skills. Where applicable, the results of specific peer review activities shall also be considered.

Reappointments are granted for a period not to exceed two years and may be granted for less than two years as recommended by the Medical Executive Committee.

4.8-1 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

a. At least four (4) months prior to the expiration date of the current Medical Staff appointment, a reapplication form developed by the Hospital and Medical Staff shall be mailed or delivered to the member. The completed reappointment application must be returned to the Medical Staff Office within 30 days of receipt. Upon receipt of the application, it shall be processed in the manner described in Section 4.5-4 through 4.5-10 of these Bylaws.

b. A Medical Staff member who seeks a change in Medical Staff status, category or modification of privileges by submitting a written request through Medical Staff Services may submit such a request at any time except that such application may not be filed within two (2) years of the time a similar request has been denied. Such application shall be processed in substantially the same manner as provided in these Bylaws regarding initial applications for Appointment. The exercise of new privileges by medical staff members shall be subject to observation in accordance with procedures adopted by the Medical Staff.

4.8-2 EFFECT OF REAPPOINTMENT APPLICATION

Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such member's:

a. Relevant practitioner specific information from organization performance improvement activities, including morbidity and mortality data, is considered and compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance;

b. Results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty;
c. Any focused professional practice evaluations;
d. Verified complaints received through documentation from patients and/or staff;
e. Compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and Hospital;
~~a.~~f. Participation in Medical Staff duties, including committee assignments and emergency call;

g. Demonstrated ethical behavior and clinical competence, current licensure, National Practitioner Data Bank query and receipt of response, and clinical judgment including professional and technical skills, in the treatment of patients.
~~b.~~h. Other reasonable indicators of continuing qualifications.

4.8-3 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a complete application for reappointment (i.e., failure to return the application within the time required by Section 4.8-1 and to make the application complete within sufficient time for it to be processed) shall result in the automatic expiration of the practitioner's Medical Staff membership and clinical privileges at the end of the current Medical Staff appointment. In the event membership terminates for the reasons set forth herein, the member shall not be entitled to any hearing or review as set forth in Article VII of the Bylaws.

4.9 LEAVE OF ABSENCE

4.9-1 REQUEST FOR LEAVE STATUS

a. Routine Leave of Absence

At the discretion of the Medical Executive Committee, a Medical Staff member may ~~obtain~~ request a voluntary leave of absence from the Medical Staff upon submitting a written request to the Medical Executive Committee no less than thirty (30) days prior to the requested effective date of the leave of absence, stating the approximate period of leave desired, which may not exceed one (1) year. Absence for longer than one (1) year shall result in automatic relinquishment of medical staff appointment and clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the end of the leave and granted by the Medical Executive Committee with TFHD Board of Directors approval., ~~but which may be extended upon request with good cause not to exceed one (1) year~~. The Medical Executive Committee shall act on such requests, using its sole discretion as to whether the requested leave of absence is in the best interests of the Hospital and the Medical Staff. Leave of absences must be requested if the Medical Staff member is going to be absent from practice for more than sixty (60) days. There shall be no right to a leave of absence; nor shall there be any procedural rights associated with failure to obtain approval for a requested leave. The member shall be notified in writing of the Medical Executive Committee decision and is only effective upon acceptance of the Medical Executive Committee.

b. Medical Leave of Absence

The Chief of Staff, in consultation with the appropriate department chair, may approve a medical leave of absence of any duration to accommodate a member's treatment for, or recovery from, a mental or physical condition affecting his or her fitness to practice safely. The member shall be notified in writing by the Chief of Staff granting the leave. The member may be required to submit a letter of release from the treating physician as a condition of return from such leave of absence and prior to exercising any patient care.

4.9.2 OBLIGATION UNDER LEAVE OF ABSENCE

During the period of the leave, the member shall not exercise privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless excused by the Medical Executive Committee.

Before any routine leave of absence may begin, all medical records must be completed and dues must be current unless excused by the Medical Executive Committee. Meeting attendance requirements will be waived during period of leave.

4.9-3 EXTENSION OR TERMINATION OF LEAVE

At least thirty (30) days prior to the proposed termination of the leave of absence, or at any earlier time, the Medical Staff member may request extension of the leave or reinstatement of privileges by submitting a written request to the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation concerning the extension of the leave or reinstatement of the member's privileges and prerogatives, and the procedures provided in Section 4.5 and 4.7 of these Bylaws shall be followed, including processing as a full reappointment under Section 4.8 if the time period since the member's appointment or last reappointment is eighteen (18) months or greater or if the member's appointment or last reappointment is expired.

4.9-4 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall result in automatic expiration of membership and clinical privileges. A member whose membership automatically expires under this provision may contest this action to the Medical Executive Committee by submitting a written statement or request a meeting before the committee. The Medical Executive Committee's decision shall be final. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

4.9-5 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

If a member's term of appointment is scheduled to expire during the period for which a leave is requested, the member may: (i) seek and obtain reappointment prior to going on leave and before the expiration of the member's current term, which would result in an adjustment of the member's subsequent term of appointment to reflect the new date of reappointment; (ii) apply for reappointment at the scheduled time while on leave, subject to the Medical Staff's prerogative that supplemental information be produced to confirm

current competence upon reinstatement; (iii) or permit the current term of appointment to expire and reapply for membership and privileges as a new candidate upon termination of the leave of absence.

4.10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment or reappointment to the Medical Staff shall not be eligible to apply again to the Medical Staff for a period of two years. Any such application shall be processed as an initial application, and the applicant shall submit any additional information that may be required to demonstrate that the basis for the earlier adverse action no longer exists along with any other information needed to demonstrate his/her qualifications.

4.11 CONFIDENTIALITY, IMPARTIALITY

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to committee meetings and the formal processes provided in these Bylaws for processing applications for appointment and reappointment.

ARTICLE V

CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a practitioner providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Those privileges and services shall be specifically delineated for each facility operated by the Hospital, and must be within the scope of any license, certificate, or other legal credential authorizing practice and consistent with any restrictions thereon. Privileges may be granted, continued, modified, or terminated by the Board of Directors only in accordance with the provisions of the Medical Staff Bylaws.

5.2 BASIS FOR PRIVILEGES DETERMINATION

Requests for privileges shall be evaluated on the basis of the applicant's education, training, experience, demonstrated professional competence and clinical performance, and the other factors specified in these Bylaws regarding qualifications for membership and privileges.

5.3 ADDITIONAL CONDITIONS FOR PRIVILEGES OF Dentists, ORAL SURGEONS, AND PODIATRISTS

5.3-1 ADMISSIONS

Dentists, oral surgeons and podiatrists who are members of the Medical Staff may only admit patients if an Active or Courtesy physician member of the Medical Staff performs the admitting history and physical examination, except the portion directly related to dentistry or podiatry, and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

5.3-2 SURGERY

a. Surgical procedures performed by dentists, oral surgeons, and podiatrists shall be under the overall supervision of the Chair of the Department of Surgery or the Chair's designee.

b. (b)Additionally, the finding, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk (as defined by the responsible department) diagnostic or therapeutic interventions.

5.3-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist, oral surgeon, or a podiatrist shall receive the same basic medical appraisal as patients admitted for other care, and a physician member of the Medical Staff shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s). This action affords no right to appeal or review under Article VII of these Bylaws.

5.4 TEMPORARY CLINICAL PRIVILEGES

5.4-1 GENERAL

Temporary privileges may be granted by the Chief Executive Officer of the Hospital or his designee on the recommendation of the department chairman and the Chief of Staff under certain circumstances to practitioners who are not members of the Medical Staff under the terms and conditions described in 5.4-2 and 5.4-3 below. Temporary privileges may be granted here for a specific period not to exceed ninety (90) consecutive days. Approval should be sought sufficiently in advance of the anticipated exercise of privileges to allow for collection and evaluation of such information in the normal course of Hospital business.

In all instances, prior to the granting of temporary privileges, there shall be:

a. a written request for temporary privileges;

b. a completed application form;

c. queries to and results from the National Practitioner Data Bank; Medical Board of California, Osteopathic Medical Board of California and/or State of Nevada, Board of Dental Examiners for California and/or Nevada, or appropriate licensing Boards for Podiatry in California and/or Nevada;

d. verification of DEA for California and/or Nevada and/or Nevada State Pharmacy registration depending upon practice location;

e. fluoroscopy certificate if applicable

f. verification of professional liability insurance meeting Medical Staff and Board of Directors specifications

g. query for and receipt of criminal background check

h. professional references for competency from previous hospital affiliation, chief or department chair familiar with the applicant's background and practice relevant to the requested temporary privileges per credentialing policy

i. other information as may be required per credentialing policy

j. evidence of no current or previously successful challenge to licensure or registration

k. evidence of no subjection to involuntary termination of medical staff membership at another organization

l. no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

m. A current valid state or federal agency picture ID card (passport or driver's license) or, at the discretion of the Medical Staff, a current valid Hospital picture ID card, in order to verify that the applicant is the same practitioner identified in the credentialing documents.

For new applicants for Medical Staff Membership and Clinical Privileges, a completed application is required which includes the above information as well as references below in 5.4-2 (a).

5.4-2 CIRCUMSTANCES

a. Pendency of Application – Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Executive Committee and Governing Board provided the application meets the criteria listed in the description above, Sections 4.2-1 and 4.5-1of these Bylaws.

b. Care of Specific Patient - A practitioner with specialized skills and experience not otherwise available on the Medical Staff or a practitioner not on the medical staff who is requested to assist with patient care by a member of the Medical Staff may be granted temporary privileges to care for a specific patient. Should the time period exceed ninety (90) days, a time limited extension of temporary privileges may be granted based on documented special circumstances. These practitioners shall have no admitting or attending physician responsibilities.

c. Locum Tenens – A practitioner who is requested by a medical staff member to cover an expected absence may be granted temporary privileges per 5.4-2 (a) above.

d. Temporary adjuncts (proctoring physician and/or visiting professor) may be granted temporary privileges for the introduction of new procedures; all outside proctors must acquire temporary privileges.

e. Other circumstances that are necessary to fulfill an important patient care need that mandates an immediate authorization to practice shall be considered for temporary privileges.

5.4-3 CONDITIONS

There is no right to temporary privileges. Temporary privileges may be granted only when the practitioner has submitted a written application for appointment to the Medical Staff, or a written request for temporary privileges, and the information available reasonably supports a favorable determination regarding appointment or the practitioner's qualifications, respectively, and the applicant has satisfied the insurance requirements of these Bylaws or Rules. The Chair of the Department to which the practitioner is assigned, or to which the privileges correspond, shall be responsible for determining the proctoring requirements or supervising the performance of any practitioner granted temporary privileges, or for designating a member of the Department to assume this responsibility. Special requirements of consultation and proctorship may be imposed by the Chair of that Department or the Medical Executive Committee. Temporary privileges will not be granted before the practitioner has acknowledged in writing that he/she has received, or has been given access to, the Medical Staff Bylaws and Rules and that he/she agrees to be bound by their terms in all matters relating to his/her Medical Staff status and the temporary privileges.

5.4-4 TERMINATION

Temporary privileges may be terminated without cause at any time by the Chief of Staff, the responsible Department Chair, or the Chief Executive Officer with the concurrence of the Chief of Staff or the responsible Department Chair. In addition, where the life or well being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Section 6.3. In the event of any such termination or restriction, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Chair of the concerned Department. The wishes of the patient will be considered, where feasible, in choosing an alternative practitioner.

5.4-5 RIGHTS OF THE PRACTITIONER

Except in cases where denial, termination, or suspension of temporary privileges must be reported to the National Practitioner Data Bank or the Medical Board of California, a practitioner or allied health professional shall not be entitled to the procedural rights afforded by Article VII because of his/her inability to obtain temporary privileges or because of any termination, suspension, or non-renewal of temporary privileges.

5.5 EMERGENCY PRIVILEGES

(a) In the case of an emergency, any member, to the degree permitted by his/her license and regardless of Departmental assignment, Medical Staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the Department Chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department Chair with respect to further care of the patient at the Hospital.

(b) In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when one becomes available.

5.6 DISASTER PRIVILEGES

(a) Disaster privileges may be granted to a non-Medical Staff member when the organization has activated its Emergency Management Plan and has determined that there are important and immediate patient care needs the Hospital is unable to meet without the assistance of practitioners in addition to those currently holding Medical Staff membership and/or clinical privileges. The Hospital Chief Executive Officer or designee, upon recommendation of the Chief of Staff or designee, may grant disaster privileges should the need arise.

(b) Privileges shall be considered on a case-by-case basis upon presentation of a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

1. A current picture hospital ID badge (card) from a hospital where the practitioner holds clinical privileges that clearly identifies professional designation;

2. A current license to practice, or primary source verification of such license;

3. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);

4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups;

5. Identification by current hospital or medical staff member(s) who possess personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

(c) Written notification/signed approval evidencing the granting of privileges shall be directed to Medical Staff Services to initiate verification. Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. (Note: In the extraordinary circumstance that primary source verification cannot be completed within 72 hours, it must be done as soon as possible with documentation as to (i) why it could not be performed within the required time frame, (ii) evidence of demonstrated ability to continue to provide adequate care, treatment, and services and (iii) an attempt to rectify the situation as soon as possible).

(d) The practitioner who has been granted disaster privileges will be provided an identification badge or other designated means of identification, to be worn during the emergency. Specific means of organization-wide communication as designated by the

incident commander (Hospital Chief Executive Officer or designee) will be utilized to disseminate basic information about non-Medical Staff member volunteer practitioners.

(e) The volunteer practitioner shall be assigned to a department of the Medical Staff under the supervision of the department chair or designee. The frequency and intensity of data collection and analysis shall be accelerated as appropriate to the emergency situation to evaluate clinical competence.

(f) The following information must be obtained, verified as soon as possible, and retained as a permanent record by Medical Staff Services:

1. Current professional license to practice including sanctions, if any
2. Photo identification, as specified above in (b)
3. Certificate of professional liability coverage
4. Current hospital affiliations
5. NPDB query (includes OIG, state sanction info, board certification, DEA information)
6. Relevant training/experience
7. Criminal background check

5.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, or pursuant to a member's request, the Medical Executive Committee may recommend a change in the privileges or Department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in the Rules regarding proctoring.

5.8 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or department assignment fails to furnish, in a timely manner, the information necessary to evaluate the request, the application shall be regarded as incomplete under Section 4.2 and shall not qualify for a credentialing recommendation. The applicant shall not be entitled to a hearing under Article VII.

5.9 CONFIDENTIALITY, IMPARTIALITY

To maintain confidentiality, and to assure the unbiased performance of privilege review functions, Medical Staff members participating in the credentialing process shall limit their discussion of the matters involved to committee meetings and the formal processes provided in these Bylaws for processing applications for clinical privileges.

5.10 ALLIED HEALTH PROFESSIONALS

5.10-1 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Allied health professionals (AHPs) are not eligible for Medical Staff membership. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of AHPs that the Board of Directors (after securing Medical Executive Committee recommendations) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Allied Health Professional

Manual. The Allied Health Professional Manual is incorporated herein by reference, as part of the Medical Staff Bylaws.

5.11 TELEMEDICINE PRIVILEGES

After consulting with the Medical Executive Committee, the Board of Directors may approve specific types of telemedicine services to be utilized at the Hospital. Such services may be provided pursuant to a contract. Practitioners who wish to provide permitted types of telemedicine services will be credentialed in accordance with this Section, but, unless they separately qualify, apply and are approved for membership in a staff category described in Article III of these Bylaws, will not be appointed to the Medical Staff in any membership category.

5.11-1 TELEMEDICINE CREDENTIALING

a. In processing a request for telemedicine privileges, the Medical Staff and Hospital may follow the normal credentialing process described in Article IV of these Bylaws, including but not limited to the collection of information from primary sources. Alternatively, the Medical Staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in this Section 5.11.

b. Telemedicine privileges shall be for a period not to exceed two years, and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these Bylaws for the renewal of clinical privileges held by Medical Staff members.

c. The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the Hospital and its Medical Staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the Medical Staff, as described in Section 2.6 of these Bylaws, modified only to take into account their distance from the Hospital.

d. Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the Medical Executive Committee or the Chief of Staff acting on its behalf, without hearing rights as described in Article VII of these Bylaws, except as required by law.

5.11-2 RELIANCE ON DISTANT-SITE ENTITIES

The Medical Staff may rely upon the credentialing and privileging decisions made by a distant-site hospital or distant-site telemedicine entity if the Hospital's Board of Directors ensures through a written agreement with the distant-site hospital or entity that all of the following provisions are met:

a. The distant-site entity acknowledges that it is a contractor of services to this Hospital and, in accordance with 42 CFR §485.635(c) (4) (ii), furnishes services in a manner that permits this Hospital to be in compliance with the Medicare Conditions of Participation.

b. The distant-site entity is either a Medicare-participating hospital or a lawful provider of the telemedicine services in question, and it confirms that its credentialing and privileging processes and standards for practitioners meet the standards described in the Medicare Conditions of Participation at 42 CFR §485.616(c).

c. The distant-site entity acknowledges, or the Hospital confirms, that the distant-site entity has a process that is consistent with the credentialing and privileging requirements of the Healthcare Facilities Accreditation Program standards for critical access hospitals (currently 05.00.14 and 05.00.15).

d. The individual distant-site practitioner holds privileges at the distant-site entity to provide the services involved, and the distant-site entity provides the Hospital with a current list of the distant-site practitioner's privileges at the distant-site entity.

e. The individual distant-site practitioner is licensed in California, or is otherwise authorized by California law, to provide the services at issue, and is covered by professional liability insurance meeting the standards that apply to Medical Staff members at this Hospital.

f. The Medical Staff of this Hospital performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to Hospital patients and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the individual distant-site practitioners. At a minimum, the information this Hospital will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this Hospital's patients, and all complaints this Hospital has received about the distant-site practitioners.

ARTICLE VI

CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND CRITERIA FOR INITIATION OF AN INVESTIGATION

6.1-1 ROUTINE MONITORING AND PEER REVIEW

Medical Staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions. They may counsel, educate, issue letters of warning or censure, or initiate focused review or retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admission and procedures) in the course of carrying out those delegated peer review functions without initiating an investigation or formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. Informal actions, focused review, monitoring or counseling shall be documented in Medical Staff minutes or Medical Staff reports. Medical Executive Committee approval is not required for such actions. Such routine peer review and quality assessment functions shall not constitute an investigation and shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights as described in Article VII of these Bylaws.

6.1-2 CRITERIA FOR INITIATION OF AN INVESTIGATION

Any person may provide information to the Medical Staff about the conduct, performance or competence of a Medical Staff Member. The Chief of Staff, a department chair, or the Chief Executive Officer may request, or the Medical Executive Committee may undertake on its own initiative, an investigation of a Member under this Article whenever reliable information indicates the Member may have exhibited acts, demeanor, or conduct reasonably likely to be 1) detrimental to patient safety or to the delivery of quality patient care within the hospital; 2) unethical, unprofessional or illegal; 3) contrary to the Medical Staff Bylaws, Rules and Regulations, or Medical Staff and Hospital administrative policy; 4) below applicable professional standards or the standards of the Medical Staff; or 5) disruptive of Medical Staff or hospital operations and the delivery of patient care.

6.2 INVESTIGATION

An investigation under these Bylaws ("Investigation") means a process specifically initiated by the Medical Executive Committee, or by the Chief of Staff on its behalf, based upon information indicating that a Member has exhibited acts, demeanor or conduct as described above in Section 6.1-2. An Investigation does not include the usual activities of departments or other committees of the Medical Staff, including the usual peer review, quality assessment and improvement activities undertaken by the Medical Staff in compliance with the licensing and certification requirements for health facilities set forth in Title 22 of the California Code of Regulations, the activities of the Medical Staff Aid Committee, or preliminary deliberations or inquiries of the Medical Executive Committee or its representatives to determine whether to order an Investigation.

6.3 INITIATION

A request for action or for an Investigation under the auspices of the Medical Executive Committee must be supported by reference to specific activities or conduct alleged. The Medical Executive Committee shall determine how to proceed. The Chief of Staff may act on behalf of the Medical Executive Committee to initiate an Investigation, subject to subsequent review and approval by that Committee. In addition, the Chief of Staff or any other Medical Staff official may, instead of initiating an Investigation, initiate or conduct such reviews as may be appropriate to his or her responsibilities under the Medical Staff's Bylaws, Rules and Regulations, or Policies.

If the Medical Executive Committee concludes an Investigation is warranted, it may conduct the investigation itself, or may assign the task to an appropriate Medical Staff official, Medical Staff department, or standing or Ad Hoc Committee of the Medical Staff. The Medical Executive Committee may in its discretion appoint members of Administration and practitioners who are not members of the Medical Staff for the purpose of assisting a standing or Ad Hoc Committee conducting an Investigation. The Member shall, at an appropriate time, be notified that an Investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigator or investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such Investigation shall not constitute a "hearing," nor shall the procedural rules with respect to hearings or appeals apply. At the conclusion of the Investigation a written summary of the findings and recommendation(s) shall be forwarded to the Medical Executive Committee. Despite the status of any Investigation, at all times the Medical Executive Committee shall have the authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the Investigative process, or other action.

6.4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the Investigation, the Medical Executive Committee shall make a decision which may include but is not limited to:

(a) Determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's credentials file;

(b) Deferring action for a reasonable time where circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand, or warning ("Letter of Reprimand"). In the event a Letter of Reprimand is issued, the affected Member may make a written response which shall be placed in the Member's file. Nothing herein shall be deemed to preclude a department or section chair, committee chair, or the Medical Executive Committee from issuing informal written or oral warnings outside of the mechanism for issuance of a Letter of Reprimand as described in these Bylaws;

(d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation or monitoring;

(e) Recommending reduction, modification, suspension or revocation of Clinical Privileges;

(f) Imposing a suspension or restriction of Clinical Privileges and/or Medical Staff membership for a duration of fourteen (14) days or less, after giving the Member written notice of the issues and an opportunity to be heard by the Medical Executive Committee;

(g) Summarily suspending or restricting Medical Staff membership and/or Clinical Privileges; and

(h) Taking other actions deemed appropriate under the circumstances, including such other actions as may be provided for in these Bylaws.

6.5 SUBSEQUENT ACTION

The Medical Executive Committee's action or recommendation following an Investigation as described herein shall be presented to the Board of Directors at its next regularly scheduled meeting.

(a) If the Medical Executive Committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the Board of Directors may be advised of the action and hearing request but shall take no action on the matter until the practitioner has either waived or exhausted his or her hearing rights.

(b) If the Medical Executive Committee decides not to take or recommend corrective action, or to take or recommended corrective action as to which the practitioner either has no rights of hearing or appeal or has waived such rights, and the Board of Directors questions or disagrees with the action of the Medical Executive Committee, the matter may be remanded back to the Medical Executive Committee for further consideration. If the decision of the Board of Directors is to take corrective action more severe than the action of the Medical Executive Committee, and a hearing is required pursuant to Article VII, the procedure shall

be as described in that Article for hearings that are prompted by action of the Board of Directors. The decision following the hearing shall be the final decision of the Hospital.

6.6 INITIATION BY BOARD OF DIRECTORS

If the Medical Executive Committee decides not to conduct an Investigation or otherwise initiate corrective action proceedings as set forth above, the Board of Directors may concur in the Medical Executive Committee's decision, or, if the Board of Directors reasonably determines the Medical Executive Committee's decision to be contrary to the weight of the evidence presented, the Board of Directors may consult with the Chief of Staff and thereafter direct the Medical Executive Committee to conduct an investigation or otherwise initiate corrective action proceedings. In the event the Medical Executive Committee fails to take action in response to a directive from the Board of Directors, the Board of Directors may, after written notification to the Medical Executive Committee, conduct an investigation or otherwise initiate corrective action proceedings on its own initiative. Any such proceedings shall afford the Member the rights to which he or she is entitled under California law. If a hearing is required pursuant to Article VII, the procedure shall be as described in that Article for hearings that are prompted by action of the Board of Directors. The decision following such proceedings shall be the final decision of the Hospital.

6.7 SUMMARY RESTRICTION OR SUSPENSION

6.7-1 CRITERIA FOR INITIATION

a. A Member's Clinical Privileges may be summarily suspended or restricted where it is believed that the failure to take such action may result in an imminent danger to the health or safety of any individual, including current or future hospital patients. Such suspensions may be imposed as an interim or precautionary measure for the protection of patients and in the absence of complete information so long as prompt steps are taken to gather information and to determine whether the suspension should be continued or discontinued, or if other less restrictive action is appropriate.

b. The following persons are authorized to impose a summary suspension or restriction: The Chief of Staff; the Medical Executive Committee, or the Chair of the Department(s) in which the Member holds Privileges. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon notice to the Member, or sooner if necessary.

c. When none of the persons listed above is available to impose a summary suspension or restriction, the Board of Directors or its designee may take such action if the Board or its designee believes that a failure to do so would be likely to result in an imminent danger to the health or safety of any individual, including current or future hospital patients. Prior to exercising this authority, the Board of Directors must make a reasonable attempt to contact the Chief of Staff. Summary action by the Board of Directors which has not been ratified by the Chief of Staff within two (2) working days after the suspension, excluding weekends and holidays, shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

d. The summary restriction or suspension may be limited in duration and shall remain in effect for the period and/or subject to the terms stated, or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the

summary restriction or suspension, the Member's patients shall be promptly assigned to another member by the department chair or appropriate clinical service chief or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

e. Unless an Investigation of the suspended practitioner is already underway at the time the summary suspension or restriction is imposed, that action shall automatically constitute a request for Investigation or action pursuant to this Article. If the Medical Executive Committee imposed the summary suspension or restriction on its own initiative, it shall determine what, if any, Investigation and further actions are warranted.

6.7-2 WRITTEN NOTICE OF SUMMARY ACTION

As soon as possible after imposition of a summary suspension or restriction, the affected Medical Staff Member shall be provided with written notice of such action. This initial written notice shall include a statement of the reasons why summary action was deemed necessary. Notice of the suspension shall also be given to the Board of Directors and, as needed, the Medical Executive Committee and the Chief Executive Officer.

6.7-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within ten (10) days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The Member shall attend and make a statement concerning the issues, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive Committee shall determine whether the summary restriction or suspension should be continued and may modify, continue or terminate the summary restriction or suspension, but in any event it shall furnish the Member with notice of its decision within two working days of the meeting.

6.7-4 PROCEDURAL RIGHTS

If the summary restriction or suspension is not lifted, the Member shall be entitled to hearing rights to the extent provided under Article VII.

6.8 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's Privileges or membership may be suspended or limited as described below. A practitioner whose membership and/or Privileges have been suspended or limited pursuant to the provisions of this Section shall not be entitled to procedural rights afforded under Article VII. However, the Member shall be given an opportunity to be heard by the Medical Executive Committee related solely to the question whether grounds exist for the special action as described above; the Medical Executive Committee shall reverse any action that was based on a material mistake of fact as to the existence of the grounds for such special action. Additional actions taken by the Medical Executive Committee on a discretionary basis shall be subject to hearing rights to the extent provided by Article VII.

6.8-1 LICENSURE

Whenever a Member's license or other legal credential authorizing practice in this state:

a. is revoked or suspended, Medical Staff membership and Clinical Privileges shall be automatically revoked or suspended, as applicable, as of the date such action becomes effective and throughout its term.

b. is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. is placed on probation or made subject to restrictions by the applicable licensing or certifying authority, his or her membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation or restrictions as of the date such action becomes effective and throughout its term.

d. lapses, expires or is not renewed by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the hospital shall be automatically suspended as of the date such expiration of licensure becomes effective. Failure to reinstate such license or other legal credential within thirty (30) days of such lapse or expiration shall result in automatic termination of Medical Staff membership and Clinical Privileges.

6.8-2 CONTROLLED SUBSTANCES

Whenever a Member's DEA certificate:

a. expires, is revoked, limited, or suspended, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. is subject to probation or conditions, the Member's right to prescribe such medications shall automatically become subject to the same terms of probation or conditions, as of the date such action becomes effective and throughout its term.

6.8-3 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Hospital and the Medical Staff. A limited suspension in the form of withdrawal of admitting and clinical privileges until medical records are completed shall be automatically imposed after notice of delinquency for failure to complete medical records within that period. The suspension shall continue until those medical records have been completed.

6.8-4 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments shall be grounds for automatic suspension of a Member's Clinical Privileges. Such suspension shall take effect automatically if the dues and assessments remain unpaid thirty (30) calendar days after the Member is given notice of delinquency and warned of the automatic suspension. If the Member still has not paid the required

dues or assessments within six (6) months after such notice of delinquency, the Member's membership shall be automatically terminated.

6.8-5 PROFESSIONAL LIABILITY INSURANCE

If at any time a Member fails to maintain continuous professional liability insurance coverage (i.e., such coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect, in whole or in part) for all of the Member's Clinical Privileges, the Member's affected Clinical Privileges shall be suspended automatically as of that date until the Chief of Staff determines there is acceptable documentation of adequate professional liability insurance coverage, which shall include, unless excused by the Medical Executive Committee for good cause, "prior acts" coverage for the period of time during which the Member had allowed his or her coverage to lapse or become noncompliant with Medical Staff requirements. If acceptable proof of such coverage is not provided to the Chief of Staff within ninety (90) days of such lapse, then the Member's Clinical Privileges and membership shall automatically terminate.

6.8-6 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENTS

Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs. It also includes submitting to mental or physician examinations, as requested by the Chief of Staff or the Medical Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's Privileges or related issues of reasonable accommodation. Failure to comply shall constitute grounds for Chief of Staff or a Department Chair to suspend the Member's Clinical Privileges or to take other appropriate action until a response is provided which is satisfactory to the requesting party. Any such suspension or action shall remain in effect until the Member is expressly notified that it is rescinded. For purposes of this Section, the information a Member can be expected to provide includes but is not limited to the following:

a. Physical or mental examinations and reports;

b. Information related to an investigation or other peer review action by another entity, including information concerning action taken by licensing or accreditation bodies and other healthcare entities;

c. Information from a Member's private office that is necessary to resolve questions that could have a bearing on the quality of care provided to patients in the Hospital; and

d. Information related to professional liability coverage and/or actions.

6.8-9 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM

Whenever a practitioner is excluded from any Federal Health Care Program, the practitioner's Clinical Privileges shall be automatically suspended as of the effective date

of such exclusion. Unless the Board of Directors determines, upon recommendation of the Medical Executive Committee, that the practitioner may still effectively practice at the hospital under such exclusion without creating unacceptable risk of penalty to the hospital or other Medical Staff members, unacceptable risk of disruption to hospital operations, or unacceptable publicity, the practitioner's Clinical Privileges and staff membership shall be terminated.

6.9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION FOLLOWING AUTOMATIC SUSPENSION OR LIMITATION

As soon as practicable after action is taken or warranted as described in Section 6.8, above, with the exception of routine suspensions for failure to complete medical records, the Medical Executive Committee shall review and consider the facts related to the automatic suspension and may recommend further corrective action as it may deem appropriate.

6.10 PRACTITIONER OBLIGATIONS

Practitioners are responsible for complying with the limitations imposed by the provisions of Section 6.8 and shall immediately provide written notice to the Medical Staff office of any of the actions or events described therein; i.e. action taken by a state licensing agency, failure to maintain adequate insurance, action by the DEA, or action by a government funded health program. Whenever this occurs, the practitioner shall also promptly provide the Medical Staff Office with a written explanation of the basis for such actions, including copies of relevant documents. The limitations described above shall take effect automatically as of the date of the underlying action or event, regardless of whether the practitioner provides notice thereof to the Medical Staff Office. The Medical Executive Committee may request the practitioner to provide additional information concerning the above described actions or events, and a failure of the practitioner to provide such information may extend the special actions listed above, even though the underlying limitation may have been removed. A practitioner's failure to observe the limitations of Section 6.8 shall be grounds for corrective action.

ARTICLE VII

HEARINGS AND APPEALS

7.1 GENERAL PROVISIONS

7.1-1 INTENT:

The intent of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as described below) and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Board of Directors from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board of Directors to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. The Medical Staff, Board of Directors, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

7.1-2 EXHAUSTION OF REMEDIES

If adverse action as described in these provisions is taken or recommended, the practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.1-3 INTRAORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly "judicial" rather than "legislative" in structure and function. The Hearing Committees have no authority to adopt new rules and standards, to modify existing rules and standards, or to resolve questions regarding the merits or substantive validity of Bylaws, Rules, Regulations or policies. Challenges to the substantive validity of any Bylaw, Rule, Regulation or policy shall be handled according to Section 7.9-2 below.

7.1-4 DEFINITIONS

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

a. "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Board of Directors in all cases where the Board of Directors or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.

b. "Practitioner" as used in this Article refers to the practitioner who may request or has requested a hearing pursuant to this Article.

c. "Day" means calendar day.

7.1-5 SUBSTANTIAL COMPLIANCE

Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or recommended by the bodies whose decisions prompted the hearing.

7.1-6 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse action by the Board of Directors, the Chair of the Board of Directors shall fulfill the functions assigned in this Article to the Chief of Staff, and the Board of Directors shall fulfill the functions assigned in this Article to the Medical Executive Committee. The procedure may be modified as warranted under the circumstances, but the practitioner shall have all of the same rights to a fair hearing.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in applicable Bylaws, Rules, Regulations or policies, any one of the following adverse actions or recommended actions shall be deemed grounds for a hearing:

(a) Denial of Medical Staff membership, reappointment and/or Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(b) Revocation of Medical Staff membership, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(c) Revocation or reduction of Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(d) Significant restriction of Clinical Privileges (except for proctoring incidental to Provisional status, new privileges, insufficient activity, or return from leave of absence) for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(e) Suspension of Medical Staff membership and/or Clinical Privileges for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients; and,

(f) Any other disciplinary action or recommendation that must be reported, by law, to the practitioner's California licensing authority under Business and Professions Code Section 805.

No actions or recommendations except those described above shall entitle the practitioner to request a hearing as described in this Article.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR RECOMMENDATION

In all cases in which action has been taken or recommended as set forth in Section 7.2, the practitioner shall be given prompt written notice of the action or recommendation including the following information:

a. A description of the action or recommendation;

b. A concise statement of the reasons for the action or recommendation;

c. A statement that the practitioner may request a hearing;

d. A statement of the time limit within which a hearing may be requested;

e. A summary of the practitioner's rights at a hearing; and

f. A statement as to whether the action or recommendation must be reported to California licensing authorities and/or the National Practitioner Data Bank.

7.3-2 REQUEST FOR HEARING

a. The practitioner shall have thirty (30) days following receipt of the notice of the action or recommendation within which to request a hearing. The request shall be in writing addressed to the Chief of Staff, and received by the Medical Staff

Office within the deadline. A copy shall also be sent to the Chief Executive Officer. Executive Officer.

b. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Said action shall thereupon become the final action of the Medical Staff. The action or recommendation shall be presented for consideration by the Board of Directors, which shall not be bound by it. If the Board of Directors ratifies the action or recommendation, it shall thereupon become the final action of the hospital. However, if the Board of Directors, after consulting with the Medical Executive Committee, is inclined to take action against the practitioner that is more adverse than the action recommended by the Medical Staff, the practitioner shall be so notified and given and opportunity for a hearing based on "an adverse action by the Board of Directors" as provided herein.

7.4 HEARING PROCEDURE

7.4-1 TIME AND PLACE FOR A HEARING

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days from the date he or she received the request for a hearing, give written notice to the practitioner of the time, place and date of the hearing. The date of commencement of the hearing shall be not less than thirty (30) days or more than sixty (60) days from the date the Chief of Staff received the request for hearing.

7.4-2 NOTICE OF REASONS OR CHARGES

Together with the notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse action taken or recommended (if not already provided), including a description of the acts or omissions with which the practitioner is charged and a list of the charts or cases in question, where applicable. The Notice of Reasons or Charges may be supplemented or amended at any time prior to the issuance of the Hearing Committee's decision, provided the practitioner is afforded a fair and reasonable opportunity to respond.

7.4-3 HEARING COMMITTEE

a. When a hearing is requested the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three (3) members of the Active Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders, or initial decision makers, and otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories. Such appointment shall include, where feasible, at least one member who has the same healing arts licensure and practices in the same specialty as the Practitioner involved.

b. Alternatively, the Chief of Staff shall have the discretion to enter into an agreement with the practitioner involved to hold the hearing before a mutually acceptable arbitrator or arbitrators. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Staff's responsibility to provide a fair hearing.

c. A majority of the Hearing Committee must be present throughout the hearing. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent.

d. The Hearing Committee or the arbitrator (if one is used) shall have such powers as are necessary to discharge its or his or her responsibilities.

7.4-4 THE HEARING OFFICER

The Chief Executive Officer shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law who is qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the hospital or medical staff for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or the procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence that are raised prior to, during, or after the hearing. If the Hearing Officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such action as he or she deems warranted by the circumstances. The Hearing Officer should participate in the deliberations of the Hearing Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

7.4-5 EXAMINATION (VOIR DIRE)

The practitioner shall have the right to a reasonable opportunity to examine (voir dire) the Hearing Committee members and the Hearing Officer, and the right to challenge the appointment of any member or the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the Hearing Officer. The Hearing Officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and Hearing Officers in proceedings of this type.

7.4-6 REPRESENTATION

a. The parties may be represented by legal counsel. However, the body whose decision prompted the hearing shall not be represented by an attorney at law if the practitioner is not so represented. The foregoing shall not be deemed to

deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing, including the identification and resolution of pre-hearing procedural issues or disputes. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed in the State of California who is not also an attorney at law.

b. In all instances, whether or not attorneys are allowed to represent the parties during the hearing, the Medical Executive Committee shall be represented by a Member of the Medical Staff who shall be responsible for representing the Medical Executive Committee's interests in connection with the peer review matter and proceeding. This responsibility shall include the authority to make decisions regarding the detailed contents of the Notice of Reasons or Charges; to make decisions regarding the presentation of testimony and exhibits; to direct the activities of the Medical Executive Committee's attorney, if any; to consult with specialists; and to amend the Notice of Reasons or Charges as he or she deems warranted during the course of the proceedings, subject to the practitioner's procedural rights. However, the Medical Executive Committee's representative shall not have the authority to modify the nature of the Medical Executive Committee's action or recommendation without the Medical Executive Committee's approval.

7.4-7 FAILURE TO APPEAR OR PROCEED; NON-COOPERATION OR DISRUPTION

Failure without good cause of the practitioner to personally attend and proceed at a hearing in an efficient and orderly manner, or serious or persistent misconduct or failure to cooperate in the hearing process by either party, shall be grounds for termination of the hearing as determined by the Hearing Committee in consultation with the Hearing Officer. Such conduct by the Practitioner shall be deemed to constitute a waiver of any hearing rights and voluntary acceptance of the recommendation(s) or action(s) involved. Such conduct by the Medical Executive Committee shall be deemed a failure to show that its action(s) or recommendation(s) are reasonable and warranted or, in the case of an initial application, a failure to present evidence in opposition to the application. The Hearing Committee's determination pursuant to this provision shall be presented for consideration by the Board of Directors, which shall exercise its independent judgment as to the appropriateness of the Hearing Committee's action in terminating the hearing.

7.4-8 POSTPONEMENTS AND EXTENSIONS

Once a timely request for a hearing has been made, postponements and extensions of the time beyond those referenced in this Article may be permitted by the Hearing Officer within his or her discretion.

7.5 DISCOVERY

7.5-1 RIGHTS OF INSPECTION AND COPYING

The Practitioner may inspect and copy, at his or her expense, any documentary information relevant to the charges that the Medical Executive Committee has in its possession or under its control. The Medical Executive Committee may inspect and copy, at its expense, any documentary information relevant to the charges that the Practitioner has in his or her possession or under his or her control. Requests for

discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

7.5-2 LIMITS ON DISCOVERY

The Hearing Officer shall rule on discovery disputes that the parties cannot resolve. Discovery may be denied or safeguards may be imposed when justified to protect peer review or in the interest of fairness or equality. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the Practitioner under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

7.5-3 RULING ON DISCOVERY DISPUTES

In ruling on discovery disputes, the factors that may be considered include:

a. whether the information sought may be introduced to support or to defend against the charges;

b. whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendation;

c. the burden imposed on the party in possession of the information sought, if access is granted, and

d. any previous requests for access to information submitted or resisted by the parties to the same proceeding.

7.5-4 PREHEARING DOCUMENT EXCHANGE

The parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. Failure to comply with this rule is a good cause for the Hearing Officer to grant a continuance, or to limit the introduction of any documents not provided to the other party in a timely manner.

7.5-5 WITNESS LISTS

Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.5-6 OBJECTIONS TO INTRODUCTION OF EVIDENCE PREVIOUSLY NOT PRODUCED FOR THE MEDICAL STAFF

The Medical Executive Committee may object to the introduction of evidence that was not provided during an appointment, reappointment or privilege application review, or during

a corrective action investigation or process despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the Practitioner can prove he or she previously acted diligently and could not have submitted the information prior to the hearing.

7.6 MISCELLANEOUS PROCEDURAL MATTERS

7.6-1 PROCEDURAL DISPUTES

a. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as soon as possible in advance of the scheduled hearing, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

b. The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the Hearing Officer.

7.6-2 RECORD OF HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the prehearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, but the cost of preparing a transcript, if any, or a copy of a transcript that has already been prepared, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only under oath administered by a person lawfully authorized to administer such oath.

7.6-3 ATTENDANCE

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following shall be permitted to attend the entire hearing in addition to the Hearing Officer, the court reporter, and the parties (with attorneys, if allowed): The Medical Staff Manager or Coordinator, one or more key consultants for each party, one or more key witnesses for each party, and the Chief Executive Officer or designee. An individual shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties.

7.6-4 RIGHTS OF THE PARTICIPANTS

Within reasonable limitations, both parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents; cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available by the other party to the Hearing Committee; and submit a written statement, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under

cross-examination. The Hearing Committee may question witnesses or call additional witnesses if it deems such action appropriate. The Hearing Officer shall also have the discretion to ask questions of witnesses if he or she deems it appropriate for purposes of clarification or efficiency.

7.6-5 RULES OF EVIDENCE

Judicial rules of evidence and procedure relating to the conduct of a trial regarding the examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these provisions. Any relevant evidence, including hearsay, may be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Notwithstanding the foregoing, the content of any settlement discussions between the parties regarding the resolution of issues in the hearing shall not be admissible.

7.6-6 BURDENS OF PRESENTING EVIDENCE AND PROOF

a. The body whose decision prompted the hearing shall have the initial duty to present evidence which supports the recommendation or action. The Practitioner shall be obligated to present evidence in response.

b. An applicant for Membership and/or Privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is sufficiently qualified to be awarded such Membership and/or Privileges at this hospital. This burden requires the production of information which allows for adequate evaluation and resolution of reasonable doubts concerning the Practitioner's current qualifications. The applicant shall not be permitted to introduce information that was not produced upon the request of any committee or person on behalf of the Medical Staff during the application process, unless the Member establishes that the information could not have been produced in the exercise of reasonable diligence. This provision shall not be construed to compel the Medical Staff to act on, or to afford a Practitioner a hearing regarding, an incomplete application.

c. Except as provided above, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Hearing Committee. If the Hearing Committee finds, based on the evidence presented at the hearing, that the action being challenged is not within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, the Hearing Committee may recommend a different result, which may be either more adverse or less adverse to the Practitioner than the action that prompted the hearing.

7.6-7 ADJOURNMENT AND CONCLUSION

The Hearing Officer may adjourn and reconvene the hearing at such times and intervals as may be reasonable and warranted, with due regard for the objective of reaching an expeditious conclusion to the hearing.

7.6-8 BASIS FOR DECISION

The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence.

7.6-9 DECISION OF THE HEARING COMMITTEE

Within thirty (30) days after the final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief of Staff, the Practitioner involved, and the Chief Executive Officer. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The decision shall include or be accompanied by a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or review as are described in these Bylaws.

7.7 APPEAL

7.7-1 TIME FOR APPEAL

a. Within ten (10) days after receipt of the decision of the Hearing Committee, either the Practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief Executive Officer and the other party in the hearing. If a request for appellate review is not received by the Chief Executive Officer within such period, the decision of the Hearing Committee shall thereupon become final, except if modified or reversed by the Board of Directors.

b. It shall be the obligation of the party requesting appellate review to produce the record of the Hearing Committee's proceedings. If the record is not produced within a reasonable period, as determined by the Board of Directors or its authorized representative, appellate rights shall be deemed waived.

c. In the event of a waiver of appellate rights by a Practitioner, if the Board of Directors is inclined to take action which is more adverse than that taken or recommended by the Medical Executive Committee, the Board of Directors must consult with the Medical Executive Committee before taking such action. If after such consultation the Board of Directors is still inclined to take such action, then the Practitioner shall be so notified. The notice shall include a brief summary of the reasons for the Board's contemplated action, including a reference to any factual findings in the Hearing Committee's Decision that support the action. The Practitioner shall be given ten (10) days from receipt of that notice within which to request appellate review, notwithstanding his or her earlier waiver of appellate rights. The grounds for appeal and the appellate procedure shall be

as described below. However, even If the Practitioner declines to appeal any of the Hearing Committee's factual findings, he or she shall still be given an opportunity to argue, in person and in writing, that the contemplated action which is more adverse than that taken or recommended by the Medical Executive Committee is not reasonable and warranted. The action taken by the Board of Directors after following this procedure shall be the final action of the Hospital.

7.7-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds of appeal, and a clear and concise statement of the facts in support of the appeal. The recognized grounds for appeal from a Hearing Committee decision are:

a. substantial noncompliance with the standards or procedures required by these Bylaws, or applicable law, which has created demonstrable prejudice; or

b. the factual findings of the Hearing Committee are not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to this section; or

c. the Hearing Committee's failure to sustain an action or recommendation of the Medical Executive Committee that, based on the Hearing Committee's factual findings, was reasonable and warranted.

7.7-3 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of a request for appellate review, schedule a review date and cause each side to be given notice of time, place and date of the appellate review. The appellate review shall not commence less than thirty (30) or more than sixty (60) days from the date of notice. The time for appellate review may be extended by the appeal board for good cause.

7.7-4 APPEAL BOARD

The Board of Directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board so long as that person did not take part in a prior hearing on the action or recommendation being challenged. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

7.7-5 APPEAL PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the proceedings before the Hearing Committee. However, the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. The appeal board shall also have the discretion to remand the matter to the Hearing Committee for the taking of further evidence or for clarification or reconsideration of the Hearing Committee's decision. In

such instances, the Hearing Committee shall report back to the appeal board, within such reasonable time limits as the appeal board imposes. Each party shall have the right to be represented by legal counsel before the appeal board, to present a written argument to the appeal board, to personally appear and make oral argument and respond to questions in accordance with the procedure established by the appeal board. After the arguments have been submitted, the appeal board shall conduct its deliberations outside the presence of the parties and their representatives.

7.7-6 DECISION

Within thirty (30) days after the submission of arguments as provided above, the appeal board shall send a written recommendation to the Board of Directors. The appeal board may recommend, and the Board of Directors may decide, to affirm, reverse or modify the decision of the Hearing Committee. The decision of the Board shall constitute the final decision of the Hospital and shall become effective immediately upon notice to the parties. The parties shall be provided a copy of the appeal board's recommendation along with a copy of the Board of Director's final decision.

7.8 RIGHT TO ONE HEARING

No practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any adverse action or recommendation.

7.9 EXCEPTION TO HEARING RIGHTS

7.9-1 EXCLUSIVE CONTRACTS

The hearing rights described in this Article shall not apply as a result of a decision to close or continue closure of a department or service pursuant to an exclusive contract or to transfer an exclusive contract, or as a result of action by the holder of such an exclusive contract.

7.9-2 VALIDITY OF BYLAW, RULE, REGULATION OR POLICY

No hearing provided for in this article shall be utilized to make determinations as to the merits or substantive validity of any Medical Staff bylaw, rule, regulation or policy. Where a Practitioner is adversely affected by the application of a Medical Staff bylaw, rule, regulation or policy, the Practitioner's sole remedy is to seek review of such bylaw, rule, regulation or policy initially by the Medical Executive Committee. The Medical Executive Committee may in its discretion consider the request according to such procedures as it deems appropriate. If the Practitioner is dissatisfied with the action of the Medical Executive Committee, the Practitioner may request review by the Board of Directors, which shall have discretion whether to conduct a review according to such procedures as it deems appropriate. The Board of Directors shall consult with the Medical Executive Committee before taking such action regarding the bylaw, rule, regulation or policy involved. This procedure must be utilized prior to any legal action.

7.9-3 DEPARTMENT, SECTION OR SERVICE FORMATION OR ELIMINATION

A Medical Staff department, section, or service can be formed or eliminated only following a review and recommendation by the Medical Executive Committee regarding the appropriateness of the department, section, or service elimination or formation. The

Board of Directors shall consider the recommendations of the Medical Executive Committee prior to making a final determination regarding the formation or elimination.

The Medical Staff Member(s) who's Privileges may be adversely affected by department, section, or service formation or elimination are not afforded hearing rights pursuant to Article VII.

ARTICLE VIII

OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer and Member-At -Large.

8.1-2 QUALIFICATIONS

Officers must be members of the Active Staff at the time of nomination and election, and must remain members in good standing during their terms of office. Failure to maintain that status shall immediately create a vacancy in the office involved. Only those members who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

(1) be members in good standing of the non-provisional Active Staff, and must remain members in good standing during their term of office. A "member in good standing" means the physician is not the subject of an adverse recommendation, as noted below:
(2) Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
(3) Not presently be serving as Medical Staff officers, Board members or chiefs at any other hospital and shall not so serve during their terms of office;
(4) Be willing to faithfully discharge the duties and responsibilities of the position;
(5) Have experience in a leadership position, or other involvement in performance improvement activities;
(6) Attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;
~~(1)~~(7) Have demonstrated an ability to work well with others.

8.1-3 NOMINATIONS

A. The Medical Staff shall provide for the election of the four (4) officers identified in Section 8.1-1, above, every two (2) years.

B. A Nominating Committee shall be convened, comprised of the Chief of Staff and two (2) other Active Staff members appointed by the Medical Executive Committee.

C. At least thirty (30) days prior to the deadline for voting as set forth in Section 8.1-4, below ("deadline for voting"), the Nominating Committee shall issue an announcement to the Medical Staff soliciting nominations for each office to be filled. Nominations may be

submitted by any member of the Active Staff, and must be received by the Medical Staff Office at least fifteen (15) days prior to the deadline for voting.

D. After the close of nominations as provided above, the Nominating Committee will screen the nominees to confirm that they meet the ~~basic~~ qualifications for office in Article 8.1-2, ~~and be willing to serve~~. Each nominee will also be contacted to confirm his or her willingness to serve if elected. The Nominating Committee will then apply the following criteria to determine, in its discretion, which nominees will appear on the ballot and for which offices:

(i) Balance of representation among specialties on the Medical Staff;
(ii) Avoidance of having more than three (3) candidates run for a given office;
(iii) Avoidance of having a single candidate run for more than one office;
(iv) The preference of the nominee regarding the office for which he or she will run, if nominated for more than one office; and
(v) Conflicting demands on the nominee if he or she is serving or has been elected to serve as Department Chair or Vice Chair.

E. In the event that the above process does not yield any qualified and willing candidates for a given office, or the Nominating Committee determines, in its discretion, that there should be one or more additional candidates for a given office, the Nominating Committee may nominate candidates on its own initiative and include them on the ballot.

F. Ballots will be issued at least five (5) days prior to the deadline for voting.

8.1-4 ELECTIONS

The election shall be by written or electronic ballot, and the outcome shall be determined by a majority of signed votes cast ~~by ballots that are returned to the Medical Staff Office no later than 72 hours prior to the annual meeting~~. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. Only members of the non-provisional Active Staff are eligible to vote in the election.

8.1-5 TERM OF ELECTED OFFICE

All officers shall serve a two (2) year term and shall take office on the first day of the Medical Staff year. At the end of that officer's term, the Chief of Staff shall automatically assume the office of the immediate Past Chief of Staff ~~and the Vice Chief of Staff shall automatically assume the office of the Chief of Staff.~~

An officer of the Medical Staff may be removed from office by a two-thirds vote of all Active Medical Staff members, for good cause, including but not limited to the following:
(a) neglect or misfeasance in office~~,~~;
(b) serious acts of moral turpitude~~,~~;
(c) failure to discharge satisfactorily the duties of office~~,~~;
(d) failure of an officer to remain a member of the Active Medical Staff in good standing shall result in automatic removal from the medical staff office;
(e) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
(f) conduct detrimental to the interests of the hospital and/or its Medical Staff;
(g) an infirmity that renders the individual incapable of fulfilling the duties of that office;

(h) or loss of confidence and support of the Medical Staff.

To bring the matter to a vote, a motion must be made and seconded at a regular or special Medical Staff meeting or by a letter to the Medical Executive Committee requesting the removal of an officer. The letter must be signed by a minimum of three (3) members of the Active Medical Staff. If a vote affirming the removal of an officer is obtained, the officer will immediately relinquish his/her position.

At least ten days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Executive Committee prior to a vote on removal.

8.1-6 VACANCIES IN ELECTED OFFICE

Vacancies of the Secretary/Treasurer during the Medical Staff year shall be filled by the Medical Executive Committee. If there is a vacancy in the Office of the Chief of Staff, the Vice Chief of Staff shall serve for the remainder of his/her term. Should the Vice Chief of Staff be elevated to fill the Chief of Staff position, a special election shall be held to fill the Vice Chief of Staff position. In the event there is a vacancy in the Office of the Vice Chief of Staff, the Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the Executive Committee.

8.2 ADMINISTRATIVE COVERAGE

When a Medical Staff, quality, or peer review issue or event needs immediate attention, in the absence of the Chief of Staff, the following representatives, in the order of succession, shall have all the powers of and be subject to all the restrictions upon the Chief of Staff, as defined in these Bylaws:

(1) Vice Chief of Staff, or
(2) Immediate Past Chief of Staff;
(3) Secretary/Treasurer;
(4) Member-At-Large;
(5) Appropriate Chief of Service or Chairman;
(6) Hospital CEO

8.2 DUTIES AND AUTHORITY OF OFFICERS

8.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief executive officer of the Medical Staff. The duties and authority of the Chief of Staff shall include, but not be limited to:

a. enforcing the Medical Staff Bylaws and Rules, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

b. exercising such authority as he/she deems necessary so that at all times patient welfare takes precedence over all other concerns;

c. in the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his/her opinion, must be accomplished prior to the next regular or special meeting of the Committee;

d. calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

e. serving with a vote as Chair of the Medical Executive Committee;

f. serving as an ex officio member of all other Medical Staff committees without vote, unless his/her membership in a particular committee is required by these Bylaws, in which case voting rights shall apply unless otherwise specified;

g. interacting with the Chief Executive Officer and the Board of Directors in all matters of mutual concern within the Hospital;

h. appointing, with the agreement of the Medical Executive Committee, committee members and chair persons for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairperson of these committees with the approval of the Medical Executive Committee;

i. representing the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer;

j. being a spokesman for the Medical Staff in external professional and public relations;

k. performing such other functions as may be assigned to the Chief of Staff by these Bylaws or the Rules, or by the Medical Executive Committee;

l. serving on liaison committees with the Board of Directors and Hospital Administration, as well as outside licensing or accreditation agencies; and,

m. being the designated person who receives reports or concerns on physician impairment.

n. continue to serve on the Medical Executive Committee, as the Past Chief of Staff, immediately following the election term for as much time as needed to assure continuity in the transition with the change in leadership.

8.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff is the second officer of the Medical Staff. The Vice Chief of Staff shall serve for two years and assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a voting member of the Medical Executive Committee and of the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. The Vice Chief of Staff shall be a member of the Quality Assessment Committee. The Vice Chief of Staff will remain on the Medical Executive Committee and serve ~~the following term as the~~ until the next Vice Chief of Staff has been elected.

8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and a member of the Joint Conference Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by the Bylaws, or by the Medical Executive Committee. The Immediate Past Chief of Staff will remain on the Medical Executive Committee for at least three (3) months to assure a smooth transition with the change in leadership and longer as deemed necessary

8.2-3 SECRETARY-TREASURER

The Secretary-Treasurer is the third officer of the Medical Staff. The Secretary-Treasurer shall be a voting member of the Medical Executive Committee. His/her duties shall include, but not be limited to:

a. maintaining a roster of Medical Staff members;
b. keeping accurate and complete minutes of all Medical Executive Committee and general and special Medical Staff meetings;
c. calling meetings on the order of the Chief of Staff or Medical Executive Committee;
d. attending to all appropriate correspondence and notices on behalf of the Medical Staff;
e. receiving and safeguarding all funds of the Medical Staff including operational and scholarship funds and presenting financial reports to the Medical Executive Committee;
f. serving on any committee as assigned; and,
g. performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

8.2-4 MEMBER-AT-LARGE

a. Perform such other functions as may be assigned by the Chief of Staff or Medical Executive Committee.

ARTICLE IX

CLINICAL DEPARTMENTS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.5 of these Bylaws. A department may be further divided, as appropriate, into different clinical services. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments. Three or more physicians on the Active Staff are required to organize a separate department.

9.2 CURRENT DEPARTMENTS

The current departments are: Anesthesia, Medicine, Surgery, Obstetrics-Pediatrics, and Emergency Medical Care.

(a) The Department of Medicine shall include the clinical services of internal medicine, mental health, family practice, diagnostic imaging, gastroenterology, and medical subspecialties.

(b) The Department of Surgery shall include the clinical services of general surgery, orthopedics, gynecology, otolaryngology, ophthalmology, urology, vascular surgery, general dentistry, pathology, plastic and reconstructive surgery, and podiatry.

(c) The Department of Obstetrics and Pediatrics shall include the clinical services of obstetrics and pediatrics.

(d) The Department of Emergency Medical Care shall include the clinical service of emergency medicine.

(e) The Department of Anesthesia shall include the clinical service of anesthesia.

9.3 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in at least one department.

9.4 FUNCTIONS OF DEPARTMENTS

Each department, functioning as a committee of the whole, is responsible for the quality of care within the Department, and for the effective performance of the following:

(a) conducting patient care reviews and utilization review through analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department with the purpose of improving care. The manner of patient care review will be outlined in the Quality Assessment Plan, and shall be approved by the Medical Staff;

(b) recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Department;

(c) conducting, participating, and making recommendations regarding educational programs pertinent to Departmental clinical practice;

(d) reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

(e) coordinating patient care provided by the Department's members with nursing and ancillary patient care services;

(f) submitting written reports to the Medical Executive Committee concerning: (1) the Department's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital; and (3) how quality and utilization review functions will be addressed;

(g) meeting regularly for the purpose of considering patient care review findings and the result of the Department's other review and evaluation activities, as well as reports on other Department and Medical Staff functions;

(h) establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

(i) taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

(j) accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Department;

(k) formulating recommendations for Departmental Rules reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff; and

(l) Recommending space and other resources needed by the Department; and assessing and recommending off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Department.

9.5 DEPARTMENT CHAIR AND VICE CHAIR

9.5-1 QUALIFICATIONS

Each department shall have a chair and vice chair who shall be a member of the Active Medical Staff and shall, if required by law, be board certified or board qualified in his/her specialty, or possess comparable qualifications and competence; and, further, shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department.

9.5-2 SELECTION

The chair and vice chair shall be elected by those members of the Department who are eligible to vote for general officers of the Medical Staff. Nominations shall be made from the floor when the election meeting is held. Vacancies due to any reason shall be filled

for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

9.5-3 TERMS OF OFFICE

Each department chair and vice chair shall serve a two (2) year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or privileges in that department. Department chairs shall be eligible, without further vote, to succeed themselves. The intention is for the Vice Chair to assume the role as chair for the following term, if elected.

9.5-4 REMOVAL

Department chairs and vice chairs may be removed from office for valid cause, including, but not limited to, to loss of confidence and support of the members of the Department, failure to cooperatively and effectively perform the responsibilities of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude. Removal of a department chair may be initiated by the Medical Executive Committee or by a petition which states the grounds for removal and is signed by at least one-third of the members of the department eligible to vote. Removal shall be considered at a special meeting called for that purpose. The grounds for the proposed removal shall be presented to the chair or vice chair in writing at least seven (7) days prior to the special meeting, and the chair or vice chair shall be given the opportunity to address the stated grounds before the matter is put to a vote. Removal shall require a two-thirds vote of department members eligible to vote on Department matters, voting either in person at the special meeting or by mail ballot.

9.5-5 DUTIES OF DEPARTMENT CHAIR

Each Department chair shall have the following authority, duties and responsibilities:

a. act as presiding officer at departmental meetings;

b. report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the Department;

c. evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that Department;

d. generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the Department through a planned and systematic process; and oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the Medical Executive Committee. At the discretion of the chair, this function may be delegated to the vice chair;

e. develop and implement Departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment;

f. be a voting member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Department;

g. transmit to the Medical Executive Committee the Department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the Department;

h. endeavor to enforce the Medical Staff Bylaws, Rules, and policies within the Department;

i. communicate and implement within the Department actions taken by the Medical Executive Committee;

j. participate in every phase of administration of the Department, including making recommendations for space and other resources needed by the Department and cooperating with the nursing service and the Hospital Administration in matters such as personnel, supplies, special regulations, standing orders, and techniques;

k. assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department, as may be required by the Medical Executive Committee; and

l. perform such other duties commensurate with the office as may from time to time be requested by the Chief of Staff or the Medical Executive Committee.

9.5-6 DUTIES OF DEPARTMENT VICE CHAIR

The vice chair shall assume all duties and authority of the chair in the absence of the chair. The vice chair will be the Department representative to the Infection Control and Pharmacy and Therapeutics Committees. . The intention is for the Vice Chair to assume the role as chair for the following term, if elected.

ARTICLE X

COMMITTEES

10.1 DESIGNATION

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a department to perform specified tasks. The purpose of Medical Staff committees shall be to monitor and improve the quality of patient care services and perform other functions related to the needs of the Medical Staff, the hospital, or applicable standards and legal requirements. Any committee, whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc, including the Medical Staff meeting as a committee of the whole, that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

10.2 GENERAL PROVISIONS

10.2-1 APPOINTMENT OF MEMBERS

a. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee.

b. A Medical Staff committee shall be composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws or Rules, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members, allied health professionals, representatives from Hospital departments such as administration, nursing services, or health information services; representatives of the community, and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with vote unless the statement of committee composition designates the position as non-voting. Unless otherwise specified in these bylaws, all non-Medical Staff members appointed to committees shall be nonvoting. When non-physician members have been granted a vote on a Medical Staff committee, such voting rights shall only be exercised relative to the practitioner's area of clinical expertise and restricted by the practitioner's scope of licensure. The Chief of Staff shall be a nonvoting, ex-officio member on all committees to which he/she is not otherwise specifically assigned.

c. The committee chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.

d. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his/her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

10.2-2 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, whichever is later, unless the member shall sooner resign or be removed from the committee.

10.2-3 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of privileges, or if any other good cause exists, that member may be removed by the Chief of Staff with the approval of the Medical Executive Committee.

10.2-4 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to that committee is made.

10.2-5 ACCOUNTABILITY

All committees shall be accountable to the Medical Executive Committee.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

a. The officers of the Medical Staff;

b. The Department chairs;

c. The Medical Director of Quality;

d. The Incline Village Community Hospital Committee Chair;

e. The Diagnostic Imaging Committee Chair; and,

f. Medical Director of Innovation and Strategic Planning

g. The Chief Executive Officer, the Chief Operating Officer, the Chief Nursing Officer, the Director of Quality, the Director of Nursing and Operations for Incline Village Community Hospital, who may attend on an ex-officio basis without a vote.

10.3-2 DELEGATION OF AUTHORITY

By adopting these Bylaws, the Medical Staff has delegated to the Medical Executive Committee the authority to perform on behalf of the Medical Staff the duties and functions described in these Bylaws, specifically including those described in this Section 10.3 and in Articles XIII and XIV. Such delegation can be limited or removed only by amendment of these Bylaws.

10.3-3 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

a. serving as the governing body of the Medical Staff, which shall include representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups;

d. recommending actions to the Board of Directors on matters of a medical-administrative nature;

e. recommending the organizational structure of the Medical Staff, the mechanism to review credentials, delineate individual clinical privileges, restrict or terminate privileges or membership and provide fair hearings, the organization of quality assessment activities and mechanisms of the Medical Staff, as well as other matters relevant to the operation of an organized Medical Staff;

f. evaluating the medical care rendered to patients in the Hospital as necessary to assure that all patients admitted or treated in any of the Hospital services receive a uniform standard of quality patient care, treatment, and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances;

g. participating in the development and approval of all Medical Staff and Hospital policies, practice, and planning;

h. reviewing the qualifications, credentials, performance and professional competence and character of applicants for both clinical privileges and/or Medical Staff membership, obtaining and considering the recommendations of the concerned departments, and making recommendations to the Board of Directors regarding Medical Staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

i. taking reasonable steps to promote ethical conduct and quality clinical performance on the part of all those requesting or holding clinical privileges and all members including requiring evaluation of performance whenever there is doubt about a practitioner's ability to perform requested privileges and/or the initiation of and participation in Medical Staff corrective or review measures when warranted;

j. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

k. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

l. reporting to the Medical Staff at each regular Medical Staff meeting;

m. assisting in the obtaining and maintenance of accreditation for the hospital and any related components;

n. developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

o. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

p. reviewing the quality and appropriateness of services provided by physicians and allied health professionals enjoying agreements with the Hospital;

q. reviewing and approving the designation of the Hospital's Authorized Representative for National Practitioner Data Bank purposes; and

r. reviewing and approving the Utilization Review and Quality Assessment Plans; and

s. initiating, approving, and/or recommending to the Board of Directors, Medical Staff Bylaws, Rules and Regulations, and Policies, and amendments and technical corrections thereto, in accordance with Articles XIII and XIV of these Bylaws.

10.3-4 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least once a month and shall maintain a record of its proceedings and actions.

10.3-5 REMOVAL OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

Medical Staff Officers and Department Chairs shall be removed from the Medical Executive Committee following removal from their respective positions as provided for in the relevant provisions of these Bylaws.

All other members of the Committee may be removed for valid cause, including but not limited to substantial neglect or misfeasance or other failure to discharge satisfactorily the duties of a Medical Executive Committee member, according to the following procedures:

a. Proceedings to remove the member may be initiated by the Medical Executive Committee or by a petition signed by at least 25% of the Medical Staff members eligible to vote for Medical Staff officers.

b. Once initiated, removal shall be considered at a regular or special meeting of the Medical Staff.

c. The grounds for removal shall be presented in writing by the Chief of Staff to the member whose removal has been proposed, at least ten (10) days before the Medical Staff meeting at which the matter will be put to a vote.

d. The member shall be given an opportunity to make a statement at the meeting regarding the asserted grounds for removal, prior to the vote. The Chief of Staff has discretion to determine whether a representative of the Medical Executive Committee or other group of Medical Staff members who proposed removal also should be given an opportunity to speak prior to the vote. The Chief of Staff may establish a reasonable time limit for any such statements.

e. Voting shall be by secret ballot marked “for” or “against” removal. The member will be removed from the Medical Executive Committee if a majority of the eligible members who cast ballots at the meeting vote “for” removal.

10.4 JOINT CONFERENCE COMMITTEE

Except as otherwise provided in Section 13.11 of these Bylaws, with respect to any conflict between the Medical Staff and the Board of Directors, the Medical Staff and Board shall meet and confer in good faith to resolve the dispute. Unless otherwise agreed, the forum for this shall be a committee composed as specified below; however, the Medical Staff and Board can utilize additional or different forums or processes, such as mediation, so long as both the Medical Staff and Board mutually agree to the forum or process as well as any procedures that would govern the process.

10.4-1 COMPOSITION

The Joint Conference Committee shall consist of the Chief of Staff, the Vice-Chief of Staff, the immediate past Chief of Staff, the Chief Executive Officer, and two (2) members of the Board of Directors appointed by the President of the Board. The Chair shall alternate at the beginning of the Medical Staff year between a Medical Staff JCC member selected by the Chief of Staff and a Board of Directors JCC member.

10.4-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for interaction

between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of Directors. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws or in the bylaws of the Hospital.

10.4-3 EXHAUSTION

Prior to seeking judicial relief over any dispute with the Hospital or Board of Directors, including any allegation that the Hospital or Board has engaged in, or is about to engage in, acts or practices that hinder, restrict or obstruct the Medical Staff's ability to exercise its rights, obligations or responsibilities, the Medical Staff must first make a reasonable effort to resolve the dispute, including the pursuit of the administrative remedies provided in these Bylaws.

10.4-4 MEETINGS

The Joint Conference Committee shall meet as often as necessary and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors.

ARTICLE XI

MEETINGS

11.1 MEETINGS

11.1-1 ANNUAL MEETING

a. There shall be an Annual Meeting of the Medical Staff in December of each year. Notice of this meeting shall be given to the members at least thirty (30) days prior to the meeting.

b. The Chief of Staff, or such other officers, Department chairs, or committee chairs as designated, may present reports on actions taken during the preceding year and on other matters of interest and importance to the members.

c. Announcement of the results of the election of officers shall occur at this meeting.

11.1-2 REGULAR MEETINGS

Regular meetings of the Medical Staff may be held each quarter, except that the Annual Meeting shall constitute the regular meeting during the quarter in which it occurs. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee, and adequate notice shall be given to the members.

11.1-3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of not fewer than ten percent (10%) of the Active Medical Staff. The request for the special meeting shall state the purpose of the proposed meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or

delivered to the members of the Medical Staff, which includes the stated purpose of the meeting.

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the committees as a whole, the chairs of committees, and Departments as a whole may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the members are given adequate notice of meeting dates. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

11.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee or Department may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, or be called by written request of ten percent (10%) of the current members, eligible to vote, but no fewer than 2 members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of twenty-five (25%) percent of the total membership of the Active Medical Staff at any regular or special meeting in person or by proxy shall constitute a quorum.

11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of one-half of the voting members shall be required for Medical Executive Committee meetings. For other committees and for Departmental meetings, a quorum shall consist of not less than two voting members.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of the majority of the members present and voting at a meeting at which a quorum is present, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meetings, or such greater number as specifically required by these Bylaws. Committee or Department action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee or Department if it is acknowledged in writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee. The Medical Staff Office shall maintain those minutes.

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the Active and Courtesy Staff shall be encouraged to attend the Annual Medical Staff meeting and required to attend at least fifty percent (50%) of all meetings of each Department (Active Staff) and committee of which he/she is a member.

Each member of the Courtesy Staff shall be required to attend such other meetings as may be determined by the Medical Executive Committee.

Failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action, pursuant to these Bylaws, up to and including revocation of Medical Staff membership.

11.6-2 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular Department, or committee meeting, the member may be requested to attend. The request shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the subject involved. Failure of a member to appear at any meeting, with respect to which he/she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for action pursuant to Section 6.4-3.

ARTICLE XII

CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Medical Staff membership or privileges within this Hospital, an applicant:

a. authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon the applicant's professional ability and qualifications;

b. authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

c. agrees to be bound by the provisions of this Article and the Bylaws and to waive to the fullest extent permitted by law all legal claims against any representative of the Medical Staff or the Hospital or any third party who acts in accordance with the provisions of this Article and the Bylaws and Rules; and

d. acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership and privileges, the continuation of that membership, and to the exercise of privileges at this Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

Minutes, files, records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff when meeting as a committee of the whole, meetings of Departments, meetings of committees established under the Bylaws, and meetings of special or ad hoc committees created under the Bylaws, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential and protected by applicable state and/or federal peer review confidentiality laws, including but not limited to California Evidence Code Section 1157 and Nevada Rev. Stat. Sections 49.119-121 and 49.265. These records and information shall become a part of the Medical Staff committee files and shall not become part of any patient files, of general Hospital records, or of any member's personal or office files.

Access to such records for Medical Staff purposes shall be limited to duly appointed officers and committees of the Medical Staff as necessary to discharge medical staff responsibilities and subject to the requirements that confidentiality is maintained. By serving on a department, Medical Staff or Hospital committee, a Medical Staff member pledges that he or she will not waive the confidentiality respecting any committee on which he or she serves, except as expressly required by law.

12.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment must be based on free and candid discussions, any breach of confidentiality of the discussion or deliberations of the Medical Staff Departments, or committees, except as authorized, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Staff or Hospital may undertake such corrective action as is deemed appropriate.

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative, agent, member, and employee of the Medical Staff and Hospital shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief by reason of providing information concerning such person.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

a. application for appointment, reappointment, clinical privileges, or specified services;

b. periodic reappraisals for reappointment, clinical privileges, or specified services;

c. corrective action and peer review;

d. hearings and appellate reviews;

e. utilization review and quality assessment, including patient care audits and morbidity and mortality reviews;

f. other Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

g. the actions of peer review organizations, state medical boards, and other entities which engage in monitoring or evaluation of professional competence or conduct, including queries and reports to or from the National Practitioner Data Bank, Medical Board of California, Nevada State Board of Medical Examiners, specialty boards, peer review organizations and other professional or health care related entities.

12.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.6 CUMULATIVE EFFECT

Provisions in these Bylaws, in the Rules and in Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

12.7 ACCESS TO MEDICAL STAFF FILES BY PERSONS WITHIN THE HOSPITAL OR MEDICAL STAFF

12.7-1 MEANS OF ACCESS

Unless otherwise stated, a person permitted access under this section shall be given reasonable opportunity to inspect the records in question and to make notes regarding them, but not to remove them or to make copies of them. Removal or copying shall be only upon the express written permission of the Medical Executive Committee.

12.7-2 PERSONS GAINING ACCESS

a. **Chief Executive Officer or Designated Representative**. The Chief Executive Officer or his/her designated representative shall have access to all Medical Staff records.

b. **Medical Staff Department Members**. The Medical Staff Department chairs and other members of the Department to the extent that they are involved in a credentialing or peer review process conducted pursuant to the Medical Staff Bylaws shall have access to the files of the Department committee on which they serve and the credentials and peer review files of practitioners under evaluation.

c. **Officers of the Medical Staff**. Officers of the Medical Staff and others carrying out official Medical Staff duties and responsibilities as provided in these Bylaws (including members of ad hoc investigative committees) shall have access to credentials and peer review files as necessary to carry out their duties and responsibilities.

12.7-3 GENERAL ACCESS BY PRACTITIONERS TO MEDICAL STAFF RECORDS

a. **Credentials and Peer Review Files**. Upon request, a practitioner shall be afforded a copy of any document in the credentialing and any peer review file concerning him/her if the document was submitted by him/her (for example, an application for Medical Staff membership or correspondence) or if the document was addressed to him/her or if its author had provided a "cc" to him/her. At the discretion of the Chief of Staff, a summary of some or all other information in these files may be provided to the practitioner.

b. **Medical Staff Committee and Department Files**. A practitioner shall have access to Medical Staff committee and Department files regarding him/her only if, following a written request by the practitioner, the Medical Executive Committee grants permission upon a showing of good cause.

12.8 ACCESS BY PERSONS OR ORGANIZATIONS OUTSIDE OF THE HOSPITAL OR MEDICAL STAFF

12.8-1 CREDENTIALING OR PEER REVIEW AT OTHER HOSPITALS

Any request for credentialing or peer review information by another institution should be presented in writing. No information shall be released until a copy of an acceptable release signed by the subject practitioner has been received from the requesting institution.

12.8-2 OTHER REQUESTS

All other requests by persons or organizations outside of the Hospital for information contained in the Medical Staff records shall be forwarded to the Chief Executive Officer. Any such request shall be in writing and shall be accompanied by a release signed by the concerned practitioner. The release of any such information shall require the concurrence of the Chief of Staff and the Chief Executive Officer.

12.8-3 SUBPOENAS AND REQUESTS FROM GOVERNMENT AGENCIES

All subpoenas and requests from government agencies for Medical Staff records shall be referred to the Chief Executive Officer. The Medical Staff Office, the Risk Manager and the Chief of Staff shall be informed of the subpoena. No documents or records will be released without consultation with the Chief of Staff, or his/her designee

12.9 RESPONSIBILITIES OF MEMBERS OF THE MEDICAL STAFF

Recognizing the importance of preserving the confidentiality of information, all individuals covered by this policy agree to respect the confidentiality of all information obtained in connection with their responsibilities. This requirement of confidentiality extends not only to the information contained in the physical files of the Medical Staff, but to the discussions and deliberations of Medical Staff committees.

12.10. INSERTION, DELETION, AND/OR CHANGES TO MEDICAL STAFF MEMBERS' CREDENTIALS FILE

12.10-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file:

a. Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members.

b. When a request is made for insertion of adverse information into the Medical Staff member's credentials file, the respective Department chair and Chief of Staff shall review such a request.

c. After such a review, a decision will be made by the respective Department chair and Chief of Staff to:

   i. not insert the information;
   ii. notify the member of the adverse information by a written summary, and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or

   iii. notify the member of the adverse information, and insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation.

d. This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

12.10-2 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION, DELETION, OR ADDITIONS TO FILE

a. When a member has reviewed his/her file as provided in accordance with Medical Staff policy and these Rules, he/she may address to the Chief of Staff a written request for correction or deletion of information in his/her credentials file. Such a request shall include a statement of the basis for the action requested.

b. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or

not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

c. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

d. In any case, a member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

ARTICLE XIII

GENERAL PROVISIONS

13.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES

Subject to approval by the Board of Directors, the Medical Executive Committee may supplement these Bylaws with Rules and Regulations or Policies that provide associated details, as it deems necessary to implement more specifically the general principles established in these Bylaws. Rules and Regulations and Policies shall become effective upon approval by the Board, which shall not be withheld unreasonably. Neither the Medical Staff nor the Board may unilaterally amend the Rules and Regulations or Policies.

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

The Medical Staff Bylaws, Rules and Regulations, and Policies shall not conflict with the Board Bylaws.

13.1-1 PROPOSALS BY THE MEDICAL EXECUTIVE COMMITTEE

a. The Medical Executive Committee shall initiate and adopt such general Rules and Regulations as it may deem necessary for the proper conduct of the Medical Staff's affairs and shall periodically review and revise the Rules and Regulations to comply with current Medical Staff practice. Additions or recommended changes to the general Medical Staff Rules and Regulations shall be generated by or submitted to the Medical Executive Committee for review and approval.

b. Any new or amended provisions for the Rules and Regulations proposed by the Medical Executive Committee shall be announced to the Medical Staff, which shall be afforded a period of at least thirty (30) days to submit written comments for consideration by the Medical Executive Committee before the provisions are submitted to the Board of Directors. Notice of the proposed provisions to the Medical Staff shall be in a reasonable manner, which may include posting in a newsletter or bulletin, distribution at a general Medical Staff meeting, or any other method regularly used by the Medical Staff Office to provide notices to members. The Medical Executive Committee may retain, modify or abandon the provisions, as it deems appropriate in light of the comments, if any. Notice of

new or amended Policies adopted by the Medical Executive Committee shall be provided to the Medical Staff promptly upon approval by the Board of Directors.

13.1-2 PROPOSALS BY PETITION

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

a. A proposal bearing the signatures of 25% or more of the voting members of the Active Medical Staff (which will constitute notice of the proposal to the Medical Executive Committee) must identify two Active Medical Staff members who will serve as representatives and act on behalf of the proposal signers in the processes described below (including any conflict management processes):

b. If the Medical Executive Committee supports a proposed amendment of the Rules and Regulations as submitted, the proposal will be disseminated to the Medical Staff for comment as described in Section 13.1-1 above, before the Medical Executive Committee submits the proposal to the Board of Directors for approval. The Medical Executive Committee is not required to submit proposed Policies or proposed Policy amendments to the Medical Staff for comment.

c. If the Medical Executive Committee does not support the proposal, it will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.

d. If the conflict is not resolved by withdrawal of the proposal, or by Medical Executive Committee support of the proposal as modified in the conflict management process, then the proposal will be submitted (in original form or, if the original proposal has been modified in the conflict management process, then as modified) to the Medical Staff for comment as described below before the proposal is submitted to the Board of Directors for approval.

e. With respect to any Rules and Regulations proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee has discretion to do any of the following:

- disseminate the proposal, as submitted, to the Medical Staff for comment;
- modify the proposal and disseminate it, as modified, to the Medical Staff for comment; or
- reject the proposal and not disseminate it to the Medical Staff for consideration.

f. With respect to any Policy proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee may accept, modify or reject the proposal without disseminating it to the Medical Staff for comment.

g. Except as otherwise provided in this Article, before the Medical Executive Committee submits any proposal for adoption or amendment of Rules and Regulations to the Community Board for approval, the Medical Executive Committee shall disseminate the proposal to the Medical Staff, as described in Section 13.1-1 above. Members of the Medical Staff shall be given an opportunity to submit written comments, through the Medical Staff Office, for a period of not less than thirty (30) days.

h. After considering any comments that have been received within the allotted period, the Medical Executive Committee may modify the proposal in light of the comments. The Medical Executive Committee will disseminate any such modified proposal to the Medical Staff, and may, in the Medical Executive Committee's discretion, solicit further comments in the manner described above.

i. If a proposal did not include the signatures of 25% or more of the voting members of the Active Medical Staff, but the Medical Executive Committee disseminated the proposal to the Medical Staff for comment, then after the comment period ends the Medical Executive Committee in its discretion may do either of the following:

- submit the proposal to the Board of Directors for approval, in its original form or as modified in light of the comments; or

- reject the proposal and not submit it to the Community Board.

13.1-3 DEPARTMENT RULES AND REGULATIONS AND POLICIES

Rules and Regulations and Policies for Medical Staff Departments may be established and amended by the same process as general Medical Staff Rules and Regulations and Policies, except that:

a. Department-initiated proposals for establishing or amending Department-specific Rules and Regulations or Policies shall be submitted to the Medical Executive Committee by the relevant Department Chair following adoption by a majority of the voting members of the Department.

b. Department-initiated proposals that are acceptable to the Medical Executive Committee as submitted may be adopted by the Medical Executive Committee and submitted to the Board of Directors for approval.

c. Each Medical Executive Committee-initiated proposal and Department-initiated proposal that the Medical Executive Committee proposes to modify or reject shall be disseminated for comment to the relevant Department, along with a statement of the Medical Executive Committee's reasons, before the Medical Executive Committee submits any such proposal to the Board of Directors for approval. The Department will have 30 days to submit responsive comments to the Medical Executive Committee in writing, and any such Department comments will be submitted to the Board along with the Medical Executive Committee's proposal.

d. If the Medical Executive Committee has rejected a Department-initiated proposal, the Department Chair (or another Department representative chosen by the Department members, if the Chair does not support the proposal) may invoke the conflict management process set forth in Section 13, 12 of these

Bylaws within 30 days of receiving notice of the rejection. If the conflict management process is not invoked timely, it will be deemed waived. If the matter is not resolved in the conflict management process, the proposal will be submitted to the Board of Directors for approval along with the written comments of the Department and the Medical Executive Committee.

e. If the Board of Directors does not approve a Department-specific proposal, the Medical Executive Committee, Department Chair, and/or designated Department representative may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice of that the Board did not approve the proposal.

13.1-4 URGENT NEED

a. If the Medical Executive Committee receives documentation of an urgent need to amend the Medical Staff Rules and Regulations to comply with law or regulation, the Medical Executive Committee may adopt the necessary amendment provisionally and submit it to the Board of Directors for provisional approval, without prior notification of the Medical Staff. Immediately following the Medical Executive Committee's adoption of such an urgent provisional amendment to the Rules and Regulations, the Medical Executive Committee will notify the Medical Staff (by an acceptable method of providing such notice as described above), and offer an opportunity for any interested Medical Staff member to submit written comments to the Medical Executive Committee within 30 days of the date of the notice. The amendment will become final at the end of the comment period if the comments indicate there is no substantial conflict regarding the provisional amendment. There is no substantial conflict unless at least 25% of voting Active Medical Staff members expresses opposition to the amendment in writing.

b. If the comments indicate a substantial conflict over the provisional amendment, then the Medical Executive Committee will implement the conflict management process set forth in Section 13.12 of these Bylaws, and may submit a revised amendment to the Board for approval if necessary.

13.1-5 ADOPTION BY THE BOARD

a. Following Medical Executive Committee approval of Medical Staff General Rules and Regulations, departmental Rules and Regulations, or Medical Staff policies as noted above, such Rules and Regulations or policies shall be come effective following approval by the Board. Board approval shall not be withheld unreasonably. Upon approval by the Board, new Rules and Regulations, Policies, or amendments to existing Rules and Regulations or Policies, shall be announced promptly to the Medical Staff in a reasonable manner, as described in Section 13.1-1(b) above.

b. If a proposal is not approved by the Board, then the Medical Executive Committee (or the designated representatives of the group of Medical Staff members who submitted a non-Medical Executive Committee-supported proposal that went directly to the Board) may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice that the proposal was not approved by the Board.

c. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations and policies.

13.1-6 ADHERENCE TO MEDICAL STAFF RULES AND REGULATIONS, MEDICAL STAFF POLICIES, AND HOSPITAL ADMINISTRATIVE POLICIES

Applicants and Members of the Medical Staff and others holding Clinical Privileges or exercising Practice Prerogatives shall be governed by all applicable Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and procedures which have been appropriately approved by the Medical Executive Committee and Board of Directors.

13.2 DUES OR ASSESSMENTS

The Medical Staff shall have the power to adopt the amount of annual dues or assessments, if any, for each category of Medical Staff membership and is solely responsible for the collection, use, and expenditure of Medical Staff funds. Medical Staff members appointed prior to July 1st of the calendar year will be required to pay dues in full. Medical Staff members appointed after July 1st of calendar year will be required to pay ½ dues.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. The words used in these Bylaws and the Rules shall be read to apply to both gender and to both the singular and the plural, as the context requires.

13.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first-class postage prepaid. The use of certified or registered mail is optional unless expressly required in these Bylaws. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained.

Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of Department, or committee (c/o Medical Staff Office, or Chief of Staff)
Tahoe Forest Hospital District
Post Office Box 759
Truckee, California 96160

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital, and, in the absence of proof of earlier receipt, shall be deemed received five days after mailing in accordance with this Section 13.4.

13.5 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS

13.5-1 GENERAL

a. Medical Staff representatives, as designated by the Chief of Staff, shall participate in Hospital deliberations affecting the discharge of Medical Staff responsibilities.

b. The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

13.5-2 EXCLUSIVE CONTRACTING DECISIONS

The Medical Executive Committee shall review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee and individual members of Medical Staff shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

13.6 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance from a company authorized to sell insurance (in the State of California for California staff members and in the State of Nevada for Incline Village Staff members) or from an insurance trust incorporated under the laws of one of the United States of America in no less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Directors and the Medical Executive Committee.

13.7 BYLAWS NOT A CONTRACT

These Bylaws describe the intended relationship between the Medical Staff and its members, as well as between the Medical Staff (including its members) and the Hospital. It is intended that all affected parties and entities shall conduct themselves in good faith conformance with these Bylaws. However, these Bylaws are not intended to be a contract, and technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or for seeking remedies that are contractual in nature.

13.8 Waiver of bylaws/RULES provisions

Insofar as is consistent with applicable laws, the Medical Executive Committee, in consultation with the Board or its designated representative, or the Board, in consultation with the Medical Executive Committee, has the discretion to waive provisions of the Bylaws or Rules, if either determines that this waiver is necessary to serve the best interests of the patients and the Hospital. There is no right to have a request for a waiver considered and/or granted.

13.9 INTERPRETATION / RECONCILIATION OF PROVISIONS

In the event of any ambiguity or in the Medical Staff Bylaws, Rules and Regulations or Policies, or should there be any question of interpretation, the Medical Executive Committee shall have the authority to resolve such matters. In the event of an apparent conflict between the Bylaws and Medical Staff Rules and Regulations, the Bylaws shall prevail. If there is a conflict between

Medical Staff Rules and Regulations and Medical Staff Policies and Procedures, the Rules and Regulations shall prevail.

13.10 MEDICAL STAFF LEGAL COUNSEL

The Medical Staff may, at its expense, retain and be represented by independent legal counsel. The authority to engage legal counsel on behalf of the Medical Staff shall be the prerogative of the Medical Executive Committee; provided, however, that if the Medical Executive Committee declines to exercise this prerogative, a majority of the voting members of the Active Staff may elect to engage legal counsel on behalf of the Medical Staff.

13.11 DISPUTES WITH THE BOARD OF DIRECTORS

In the event of a dispute between the Medical Staff and the Board of Directors relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code section 2282.5, the following procedures shall apply:

13.11-1 INVOKING THE DISPUTE RESOLUTION PROCESS

a. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25% of the members of the Active Staff.

b. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the Active Staff.

13.11-2 DISPUTE RESOLUTION FORUM

a. Ordinarily, the initial forum for dispute resolution should be the Joint Conference Committee.

b. However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Board of Directors. A neutral mediator acceptable to both the Board of Directors and the Medical Executive Committee may be engaged to further assist the dispute resolution upon request of (a) at least a majority of the Medical Executive Committee plus two members of the Board of Directors; or (b) at least a majority of the Board of Directors plus two members of the Medical Executive Committee.

13.11-3 FINAL ACTION

If the parties are unable to resolve the dispute the Board of Directors shall make its final determination, giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Board of Directors' determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

13.12 DISPUTES INTERNAL TO THE MEDICAL STAFF

(a) Under the following circumstances, the Medical Executive Committee shall initiate a conflict management process to address a disagreement between members of the Medical Staff and the Medical Executive Committee about an issue relating to the Medical Staff's documents or functions, including but not limited to a proposal to adopt or

amend the Medical Staff Bylaws, Rules and Regulations, or Policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical Staff under these Bylaws (by amending the Bylaws):

(1) upon written petition signed by either:
- at least 25% of the voting members of the Medical Staff, or
- at least 66% of the members of any Department of the Medical Staff; or

(2) upon the Medical Executive Committee's own initiative at any time; or

(3) as otherwise specified in these Bylaws.

(b) A request to invoke the conflict management process must be submitted within any deadline specified in these Bylaws.

(c) A petition to initiate the conflict management process shall designate two Active Medical Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process should be utilized to address it.

(d) With respect to each particular conflict, the Medical Executive Committee shall determine and specify a process that the Medical Executive Committee deems most appropriate to the issues and circumstances. At a minimum, the conflict management process shall do all of the following:

- provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views;
- require good-faith participation by representatives of the parties; and
- provide for a written decision or recommendation by the Medical Executive Committee on the issues within a reasonable time, including an explanation of the Medical Executive Committee's rationale for its decision or recommendation.

(e) At the Medical Executive Committee's discretion, the process for management of a conflict between the Medical Executive Committee and Medical Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

(f) This conflict management process shall be a necessary prerequisite to any proposal to the Board of Directors by Medical Staff members for adoption or amendment of a Bylaw, Rules and Regulations provision, or Policy not supported by the Medical Executive Committee, including (but not limited to) a proposed Bylaws amendment intended to remove from the Medical Executive Committee some authority that has been delegated to it by the Medical Staff.

(g) Nothing in this Section is intended to prevent Medical Staff members from communicating with the Board of Directors about Medical Staff Bylaws, Rules and Regulations, or Policies, according to such procedures as the Board may specify.

13.13 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by an appropriate practitioner, i.e., an MD or DO, DDS, DPM, Clinical Psychologist, oral maxillofacial surgeon, or other qualified licensed individual in accordance with California and/or Nevada law as applicable and the Medical Staff Rules and Regulations.

Whenever the medical history and physical examination have been completed before admission or registration (which may occur only as permitted in accordance with this Section and applicable law and accreditation requirements), an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by an appropriate practitioner, as defined above.

Additional requirements for completing the medical history and physical examination for each patient are set forth in the Medical Staff Rules and Regulations.

ARTICLE XIV

ADOPTION AND AMENDMENT OF BYLAWS

14.1 Medical Staff responsibility and authority

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments, which shall be effective when approved by the Board of Directors. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board of Directors. Amendments to these Bylaws may be submitted for vote by the Medical Executive Committee or by petition signed by at least ten percent (10%) of the voting member of the Medical Staff.

14.2 METHODOLOGY

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

(a) The affirmative vote of two-thirds (2/3) of the Staff members voting on the matter by mailed secret ballot; provided at least 14 days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and

(b) Amendments shall become effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Medical Staff bylaws or rules.

In recognition of the ultimate legal and fiduciary responsibility of the Board of Directors, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Board of Directors to such effect including a reasonable period of time for response, the Board of Directors may impose conditions on the

Medical Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, Medical Staff recommendations and views shall be carefully considered by the Board of Directors in its actions.

The Medical Staff Bylaws, Rules and Regulations and policies will not conflict with the Governing Board Bylaws.

14.3 AMENDMENTS BY PETITION

Generally, proposals to adopt, amend or repeal Bylaws will emanate from or be endorsed by the Medical Executive Committee in accordance with its overall responsibility to represent and act on behalf of the Medical Staff and discharge its various functions as described in Section 10.3 of these Bylaws. However, in addition to the mechanisms set forth above by which the Medical Staff may adopt Medical Executive Committee-proposed amendments to these Bylaws, the Medical Staff may adopt and propose Bylaw amendments directly to the Board of Directors for its approval, but only in accordance with the following procedure:

(a) A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Office a petition signed by at least 10% of Active Medical Staff members proposing a specific Bylaws amendment or amendments (which will constitute notice of the proposed Bylaws amendment(s) to the Medical Executive Committee). Any such petition must identify two Active Medical Staff members who will serve as representatives and act on behalf of the petition signers in the processes described below (including any conflict management processes).

(b) Upon submission of such a petition, the Medical Executive Committee will determine whether it supports the proposed Bylaws amendment(s), and if so, the Medical Staff Office will arrange for a vote on the proposed Bylaws amendment(s) by the voting members of the Active Medical Staff according to the process described above for voting on Medical Executive Committee-proposed Bylaws amendments.

- If the Medical Staff adopts the proposed Bylaws amendment(s) by a vote of the Medical Staff conducted according to the process described above, then the proposed Bylaws amendment(s) will be submitted to the Board of Directors for approval.

- If the Medical Staff does not adopt the proposed Bylaws amendment(s) by vote, then the proposed Bylaws amendment(s) will be deemed withdrawn.

(c) If the Medical Executive Committee does not support the proposed Bylaws amendment(s), the Medical Executive Committee will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed Bylaws amendment(s) will be deemed withdrawn.

(d) If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s), or by Medical Executive Committee support of the proposed Bylaws amendment(s) as modified in the conflict management process, then the proposed Bylaws amendment(s) will be submitted (in original form or, if the original proposed Bylaws amendment(s) has/have been modified in the conflict management process, then as modified) to the Medical Staff for a vote. The proposed Bylaws amendment(s) will be submitted to the Board of

Directors if a majority of the Active Medical Staff members who are eligible to vote cast their ballots in favor of the proposed Bylaws amendment(s).

(e) A copy of the Medical Executive Committee's written statement of its decision and reasons issued at the conclusion of the conflict management process shall be provided to the Board of Directors along with any proposed Bylaws amendment(s) submitted to the Board after such process.

(f) Such proposed Bylaws amendment(s) will become effective immediately upon Board approval, which shall not be withheld unreasonably.

(g) If the Board of Directors does not approve the proposed Bylaws amendment(s), then the matter will be referred to the conflict management process set forth in Section 13.11 of these Bylaws.

14.4 EXCLUSIVITY

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.5 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and the Board of Directors.

TAHOE FOREST HOSPITAL DISTRICT

MEDICAL STAFF
RULES AND REGULATIONS

2016

MEDICAL STAFF RULES AND REGULATIONS

MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I

PREAMBLE

1.1 These Rules are intended to provide for the operation and governance of the Medical Staff in accordance with the guidance and structure set forth in the Medical Staff Bylaws ("Bylaws"). In the event of any conflict between the Bylaws and the Rules, the Medical Staff Bylaws shall prevail.

1.2 All Rules contained herein have been recommended by the Medical Executive Committee of the Tahoe Forest Hospital District Medical Staff and approved by the Board of Trustees in accordance with Section 13.1 of the Medical Staff Bylaws. These Rules are binding on all Members of the Medical Staff and holders of clinical privileges, to the extent consistent with the Bylaws.

1.3 All definitions contained in the Bylaws are incorporated in these Rules.

ARTICLE II

COMMITTEES

2.1 ETHICS COMMITTEE

2.1-1 COMPOSITION

The Ethics Committee shall be composed of at least the following members: One physician, one registered nurse, one clergy, one medical social worker (or comparable), one member of Hospital administration, and one non-Hospital local community member at large. Additional members may be appointed by the Chief of Staff. The chairperson shall be a physician appointed by the Chief of Staff, and the vice-chairperson shall be a member selected by the Ethics Committee.

2.1-2 PURPOSE

The purpose of the Ethics Committee is to impact positively upon the quality of health care provided by the Hospital by:

(a) Providing assistance and resources in decision-making processes that have bioethical implications. The Ethics Committee shall not, however, be a decision maker in any such processes.

(b) Educating members within the Hospital community of bioethical issues and dilemmas.

(c) Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

(d) Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and educative guidance relating to such matters.

2.1-3 MEETINGS

The Ethics Committee shall meet as often as necessary to accomplish its purpose and shall maintain a limited record of its proceedings and report its activities to the Medical Executive Committee.

2.2 BYLAWS COMMITTEE

2.2-1 COMPOSITION

The Bylaws Committee shall consist of at least three (3) members of the Medical Staff, including at least the Vice Chief of Staff and a past Chief of Staff appointed by the Chief of Staff.

2.2-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) conducting a periodic review of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and it's Departments;

(b) submitting recommendations to the Medical Executive Committee for changes in these documents as necessary and desirable; and

(c) receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of those items.

2.2-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

2.3 QUALITY ASSESSMENT COMMITTEE

2.3-1 COMPOSITION

The Quality Assessment Committee shall consist of a chair of the Committee appointed by the Chief of Staff in consultation with Administration, interested physicians from each clinical Department, and such members as may be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, including representatives from the Quality Department, Nursing Services, and from Hospital Administration. The chair shall be the Medical Director of Quality Assessment and will also serve as the physician representative to the Critical Access Hospital Committee at Tahoe Forest Hospital.

2.3-2 DUTIES

The Quality Assessment Committee shall perform the following duties:

(a) Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These may include mechanisms to:

(1) establish systems to identify potential problems in patient care;

(2) set priorities for action on problem correction;

(3) refer priority problems for assessment and corrective action to appropriate Department or committees;

(4) monitor the results of quality assessment activities throughout the Hospital; and

(5) coordinate quality assessment activities.

(b) Submit regular reports to the Medical Executive Committee and Board of Directors on the quality of medical care provided, quality review activities conducted, and Professional Review Committee (PRC) and Professional Performance Evaluation Committee (PPEC) functions:
(1) Periodic review of Peer Review Policy
(2) Review of individual cases as requested by department Chairs.

(c) Risk management practices as they relate to aspects of patient care and safety within the Hospital, and ensure that the Medical Staff actively participates, as appropriate, in the following risk management activities related to the clinical aspects of patient care and safety:

(1) The identification of general areas of potential risk in the clinical aspects of patient care.

(2) The development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety and evaluation of these cases.

(3) The correction of problems in the clinical aspects of patient care and safety identified by risk management activities.

(4) The design of programs to reduce risk in the clinical aspects of patient care and safety.

(d) Medical Records: Review and evaluate health information management including paper and electronic health records for compliance with Hospital needs and regulatory requirements. Additional medical record functions include:

(1) ensuring that medical records are maintained at an acceptable standard of completeness
(2) submitting written reports to the Medical Executive Committee and providing recommendations to the Medical Executive Committee regarding corrective action recommendations pertaining to compliance with medical records policies;
(3) recommending new use or changes in the format of medical records;
(4) recommending policies for medical record maintenance including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement; and policies related to privileged communication and release of information;

(e) Blood Usage: The Quality Assessment Committee shall receive quarterly reports to evaluate blood and blood product transfusion appropriateness and usage.

(f) Drug Usage: The Quality Assessment Committee shall be responsible for the oversight of the Pharmacy and Therapeutics Committee and an annual review of the Medication Error Reporting Policy (MERP)

(g) Infection Control: The Quality Assessment Committee shall be responsible for the oversight of the Infection Control Committee.

(h) Tissue Review: The Quality Assessment Committee shall also be responsible for receiving quarterly reports from a pathologist, who is a member of the Medical Staff with privileges in pathology concerning (I) pre-operative, post-operative, and pathological diagnoses for surgical cases in which no specimen is removed; (II) all transfusions of whole blood and blood derivatives;(III) all removed tissue where the tissue is found to be normal or not consistent with clinical diagnosis. Any cases not meeting criteria established by policy shall be referred to the appropriate Medical Staff Committee or Department for discussion.

(i) The Quality Assessment Committee shall review all deaths and all removed tissue where the tissue is found to be normal or not consistent with the clinical diagnosis, and shall develop and implement measures to correct any problems discovered. It shall develop rules governing which cases must be reviewed, and outlining any exceptions to this general rule. Such rules shall be subject to Medical Executive Committee and Board of Directors approval. The Quality Assessment Committee shall also develop and implement measures to promote autopsies in all cases of unusual death or deaths of medico-legal or educational interest.

(j) The Quality Assessment Committee shall review utilization of resources as they relate to aspects of patient care within Hospital-provided services as outlined in the Utilization Review Plan.

(k) Surgical and other invasive procedures, including: selecting appropriate procedures; preparing the patient for the procedure; equipment availability; safety of the environment; performing the procedure and monitoring the patient; and providing post-procedure care.

(l) Radiation Safety: Report from Radiation Safety Officer regarding research, diagnostic, and therapeutic uses of radioactive materials

(i) Reduction of both personnel and patient exposure to the minimum while pursuing the medical objective.
(ii) All applications for uses or authorizations for uses of radiation will be reviewed by the Radiation Safety Officer to assure that “as low as reasonably achievable” (ALARA) exposures will be maintained.
(iii) When reviewing new uses of radiation, details of efforts of applicants to maintain exposures ALARA must be included.

(m) Imaging Services: The Quality Assessment Committee shall be responsible for establishing, approving and enforcing policies relating to administration of imaging services through the hospital; and

(i) Conducting, approving and interpreting a quality assessment review for radiology services

(n) The Quality Assessment Committee shall be responsible for annual review of the following:

(i) All clinical/critical pathways.
(ii) Quality Assessment Plan.
(iii) The Utilization Review and Discharge Plan.
(iv) The Risk Management Plan
(iv) The Patient Safety Plan.
(v) The Social Service Plan.

2.3-3 MEETINGS

The Committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

2.4 INTERDISCIPLINARY PRACTICE COMMITTEE

2.4-1 COMPOSITION

The Interdisciplinary Practice Committee shall include, at a minimum, the Chief Nursing Officer, the Chief Executive Officer or designee, and an equal number of physicians appointed by the Medical Executive Committee of the medical staff, and registered nurses appointed by the Chief Nursing Officer. In addition, representatives of the various allied health professions should serve as consultants on an as-needed basis, and, if available, may be included in the committee proceedings when a member of the specialty is applying for privileges.

The chair of the Committee shall be appointed by the Chief of Staff.

2.4-2 DUTIES

The Interdisciplinary Practice Committee shall establish written policies and procedure for the conduct of its business including making recommendations regarding the granting of expanded role privileges to registered nurses, whether or not employed by the facility and other allied health professionals. These policies and procedures will be administered by the Committee which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges for allied health professionals. The Committee shall be responsible for the formulation and adoption of standardized procedures and for initiating the preparation of such standardized procedure in accordance with Title 22.

2.4-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Board of Directors.

2.5 WELL-BEING COMMITTEE

2.5-1 COMPOSITION

(a) In order to improve the quality of care and promote the competence of the Medical Staff, the Chief of Staff, with the approval of the Medical Executive Committee, shall appoint the Well-Being Committee composed of at least two (2) active members of the Medical Staff. The majority of the committee, including the chair, shall be physicians.

(b) Individuals who are not members of the Medical Staff (including non-physician(s)) may be appointed when such appointment will materially increase the effectiveness of the work of the committee.

(c) The members shall be appointed as appropriate to achieve continuity.

(d) Insofar as possible, members of this committee shall not serve as active participants

on other peer review or quality assurance committees while serving on this committee.

2.5-2 DUTIES

(a) The Well-Being Committee shall serve as an identified resource to take note of and evaluate issues related to health, well-being, or impairment of Medical Staff members and shall provide assistance to Department Chairs and Medical Staff officers when information and/or concerns are brought forth regarding a Practitioner's health or behavior related to physical, emotional, or drug dependency related conditions.

(b) The committee shall provide advice, recommendations and assistance to any practitioner who is referred and to the referring source, but shall act only in an advisory capacity and not as a substitute for a personal physician.

(c) The Well-Being Committee will receive reports, information and concerns related to the health, well-being, or impairment of Medical Staff members, whether from third parties, upon request of a Medical Staff or department committee or office or upon self-referrals from the practitioners themselves and, as it deems appropriate, may investigate such reports.

(d) With respect to matters involving individual Medical Staff members, the committee may offer advice, counseling, or referrals as may seem appropriate.

(e) Activities shall be confidential; however, if unreasonable risk of harm to patients is perceived, that information must be referred to appropriate officials of the Medical Staff for action as necessary to protect patients and/or for corrective action.

(f) The committee shall assess and determine appropriate outside assistance resources and programs for practitioners also consider general matters related to the health and well being of the Medic al Staff and, with the approval of the Medical Executive Committee, shall develop educational programs or related activities.

(g) The Committee will make a response to the referral source of any written letter of concern regarding well-being but shall not compromise the confidentiality of its activities or the privacy of the individuals concerned.

(h) The Well-Being Committee may be asked to review responses form applicants concerning physical or mental disabilities, and recommend what, If any, reasonable accommodations may be indicated to assure that the practitioner will provide care in accordance with the Hospital and Medical Staff's standard of care. The timing of these assessments shall be closely coordinated so that the Medical Executive Committee does not consider the issue of physical or mental disabilities until after an applicant has been otherwise determined to be qualified for Medical Staff membership. The Committee shall also perform this function during a Staff membership. The Committee shall also perform this function during member's term, upon request from the Medical Executive Committee.

2.5-3 MEETINGS

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings, as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee. Any records regarding individual practitioners shall be kept strictly confidential and maintained separate from credentials files and other Medical Staff

records.

2.6 CANCER COMMITTEE

2.6-1 COMPOSITION

The Cancer Committee is a standing committee of the Medical Staff. It is multidisciplinary and provides leadership to the Cancer Program. The Cancer Committee and Cancer Conference are also known as the Tahoe Forest Hospital's Tumor Board.

The Cancer Committee shall be a multidisciplinary committee composed of physician representatives who care for cancer patients including, but it is not limited to the following:

a. Cancer Committee Chair
b. Cancer Liaison physician
c. Diagnostic Radiologist
d. Medical Oncologist
e. Radiation Oncologist
f. Pathologist
g. Surgeon
h. Gynecologist

Non-physician members must include, but are not necessarily limited to, the following:

a. Cancer program Administrator
b. Oncology nurse
c. Social Workers and/or Case Manager
d. Certified Tumor Registrar
e. Performance Improvement or quality management representative
f. Hospice manager
g. Palliative Care Nurse Specialist
h. Clinical Research Coordinator
i. CoC Appointed Coordinators
j. American Cancer Society Representative
k. Nurse Navigator

The Cancer Committee chair is elected by the physician committee membership for a 2 year term and may also fulfill the role of one of the required physician specialties. Individual members of the Committee are appointed to coordinate important aspects of the Cancer Program. An individual cannot fulfill more than 1 coordinator role (for the CoC appointed coordinator positions). Each person coordinates one of each of the following four major areas of program activity:

a. Cancer Conference
b. Quality Control of Cancer Registry Data
c. Quality Improvement
d. Community Outreach
e. Clinical Research
f. Psychosocial Services

2.6.2 DUTIES

a. The Cancer Committee develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and programmatic endeavors related to cancer care;
b. The Cancer Committee establishes the frequency, format and multidisciplinary attendance requirements for cancer conferences on an annual basis;

c. The Cancer Committee ensures that the required number of cases are discussed at the Cancer Conference on an annual basis and that a minimum of 75% of the cases discussed are presented prospectively;
The Cancer Committee monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective cases presentation annually. Each year, the Cancer Committee participates in the CoC CP3R National Data Outcomes measures. Committee annually reviews outcomes, develops outcomes as indicated and follows the measures through to Quality Improvements projects.

Each year, the Cancer Committee analyses patient outcomes and disseminates the results of the analysis. This will be accomplished by publishing an Annual Report that includes a cancer site analysis with survival analysis and comparison of our data to NCDB data.

2.6.3 MEETINGS

The Committee shall meet at least quarterly, for a minimum of 4 times each year or as often as necessary at the call of its Chair (currently meets every other month for a total of six meetings per year)). It shall maintain a record of its proceedings and report its activities to the Medical Staff Quality Assessment Committee. Each member is required to attend at least 75% of the Cancer Committee meeting held annually. Participation may include through teleconference. The Cancer Committee needs to monitor the individual attendance of all members and address attendance that does not fulfill the needs of the program or falls below the requirements set forth.

2.7 CANCER CONFERENCE

2.7-1 COMPOSITION:

The Cancer Conference reports to the Cancer Committee. The Cancer Conference shall consist of a multidisciplinary group of physicians including the major disciplines involved in the management of cancer; surgery, medical oncology, radiation oncology, diagnostic imaging and pathology and other specialties as needed. The Chair will be elected by the Cancer Committee**.**

2.7-2 DUTIES

(a) Utilize the clinical case presentation format to educate the staff in oncology and oncologic
practice;
(b) Promote an active interchange of ideas for case management, assuring that patients with malignancies will benefit from the combined thinking of the staff;
(c) Ensure that a broad base of oncology knowledge is available, either from within the Cancer Conference, or from guest participants;
(d) Accept and consider any responsible and practical method established by a hospital to evaluate cases of malignancy. Whether done by a representative cross section of the staff or specified departments, evaluations shall reflect a broad base of knowledge of oncology, assuring that all patients with malignancies will benefit from the combined thinking of the staff in case management.
(e) Report on new trends in the diagnosis and therapy of malignancy;
(f) Encourage presentations to the Cancer Conference early in the patient's management;
(g) Recommend the most appropriate diagnostic and therapeutic approaches for the patients presented and their malignancies;
(h) Cases presented, at a minimum, include 15% of the annual analytic case load) and

the prospective presentation rate (a minimum of 80% or a maximum of 450 of the annual analytic case presentations). Prospective cases include, but are not limited to, the following:

(i) 1. Newly diagnosed and treatment not yet initiated;
(j) 2. Newly diagnosed and treatment initiated, but discussion of additional treatment is needed;
(k) 3. Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed;
(l) 4. Previously diagnosed, and discussion of supportive or palliative care is needed;
(m) 5. Note that cases may be discussed more than once and counted each time as a prospective presentation if management issues are discussed.

Cancer Conference activities are reported to the Cancer Care Committee at least quarterly.

2.7.3 MEETINGS

The Cancer Conference is held monthly or as often as necessary at the call of its chair. Each member is required to attend at least 50% of the Cancer Conferences. The Cancer Committee reviews the annual Cancer Conference attendance rate to ensure compliance with the CoC standard.

2.8 INCLINE VILLAGE COMMITTEE

2.8-1 COMPOSITION

(a) The Incline Village Committee shall consist of all physicians who are on the Medical Staff and exercising clinical privileges at Incline Village Community Hospital.

(b) The Chairperson shall be elected on a bi-annual basis by majority vote of physicians on the committee. The Chairperson shall serve for a three (3)-year term with election held 3 months prior to the last meeting of the calendar year. In addition to the physicians, there will be representation by nursing and Hospital administration.

(c) All medical and hospital staff may attend the Open Session of this meeting, however, agenda Items must be cleared In advance with the Chairperson.

(d) The Chairperson will serve as liaison between the Administration and the physicians practicing at Incline Village Community Hospital. The Chairperson will report directly to the Medical Executive Committee and attend Medical Executive Committee as a voting member.

2.8-2 DUTIES

a) Review policies and procedures relating to nursing and ancillary services throughout the Incline Village Community Hospital.

b) Conduct all quality review of care at Incline Village Community Hospital with further review or optional alternative review by appropriate Tahoe Forest Hospital District Medical Staff departments if requested. Those specialties that only have one

physician representing the specialty will have cases reviewed by the appropriate department of the Tahoe Forest Hospital District Medical Staff . (Department of Surgery will review surgical cases, etc.)

c) Conduct, participate, and make recommendations regarding educational programs pertinent to clinical practice;

d) Reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

e) Coordinate patient care provided at Incline Village Community Hospital by the Medical Staff with nursing and ancillary patient care services;

f) Submit written reports to the Medical Executive Committee concerning: (1) the Committee's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided at Incline Village Community Hospital and the Hospital; and (3) how quality and utilization review functions will be addressed;

g) Meet regularly for the purpose of considering patient care review findings and the result of the Committee's other review and evaluation activities, as well as reports on other Committee and Medical Staff functions;

h) Take appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

i) Account to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Committee; and

j) Recommend space and other resources needed by the Committee; and assess and recommend off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Committee.

2.8-3 MEETINGS

The Incline Village Committee shall meet on a quarterly basis. Additional meetings or cancellations may be determined by the Chairperson. A Committee report will be submitted to the Medical Executive Committee for review. Each member of the Active Staff whose primary practice is at Incline Village Community Hospital shall be encouraged to attend the Annual Medical Staff meeting; and required to attend at least fifty percent (50%) of all meetings of the Incline Village Committee or the appropriate Tahoe Forest Hospital Department meetings. There will be no exceptions from the meeting attendance requirements.

~~2.9 PHARMACY AND THERAPEUTICS COMMITTEE~~

~~2.9-1 COMPOSITION~~

~~The Pharmacy and Therapeutics Committee shall consist of at least one physician, one pharmacist, the Director of Nursing Service or her representative, and the Administrator or his representative. The Chair and members will be appointed by the Chief of Staff., with the agreement of the Medical Executive Committee.~~

2.9-2 DUTIES

The Pharmacy and Therapeutics Committee shall perform the following duties:

(a) Assist in formulation of professional practices and policies which will be reviewed annually regarding the evaluation, appropriateness, safety, effectiveness, appraisal, selection, procurement, storage, distribution, dispensing, use, safety procedures, and with the focus of minimization of drug errors and all other matters relating to drugs in the Hospital, including antibiotic usage;

(b) Report to and serve as a liaison with the Medical Staff and the Pharmaceutical Service on matters pertaining to the choice and use of available drugs;

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) Develop a hospital formulary or list of drugs for use in the Hospital, amend the formulary or drug list as needed, and the formulary is reviewed at least annually;

(e) Monitor antibiotic utilization.

(f) Consider individual physician's requests for review or additions to the formulary by evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;

(g) Formulate procedures for reporting adverse drug reactions and errors in administration of drugs with Medical Staff participation in the investigation and evaluation of these issues and implement appropriate action to correct identified problems and improve medication administration safety;

(h) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs under the oversight of an outside IRB;

(i) Maintain a record of all activities relating to pharmacy and therapeutic functions and submit periodic reports and recommendations to the QA Committee and the Medical Executive Committee concerning those activities;

(j) Review annually the Medication Use Review or Drug Utilization Effectiveness Plan and review quarterly the medication use summary and address actual improvements and report to the appropriate Medical Staff Departments and Medical Staff Quality Committee.

2.9-3 MEETINGS

The Committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its proceedings and report its activities and recommendations to the Quality Committee and Medical Executive Committee.

2.10 INFECTION CONTROL COMMITTEE (ICC)

2.10-1 COMPOSITION

The IC function is supported by the Infection Control Committee (ICC), whose Chairperson is appointed by the Chief of Staff. Consultation with an Infectious Disease physician and the medical

director for the clinical laboratory is available. Members of the ICC include at least 3 physicians from the Medical Staff and other ancillary staff including but not limited to: Administration, appropriate clinical staff, microbiology representation, and infection control.

2.10-2 DUTIES

Committee members approve policies and procedures, review quality indicator reports, make decisions about interventions related to infection prevention and control, and provide feedback and follow-up through their participation in the IC program. Committee members also:

(a) Review and approve the annual Infection Control Plan;

(b) Forward findings and recommendations to the Medical Staff Quality Committee, the Medical Executive Committee, the Board of Directors, Safety and other facility-specific committees;

(c) Collaborate with all stakeholders and provide ongoing consultation regarding all aspects of the Infection Control Program;

(d) Identify epidemiologically important issues, set specific annual objectives, and modify the Infection Prevention and Control Plan to meet those objectives;

(e) Review surveillance data monitoring for trends in infections, clusters, infections due to unusual pathogens, or any occurrence of nosocomial infections that exceed the baseline levels;

(f) Review infection prevention and control issues regarding employee health;

(g) Review antibiotic susceptibility/resistance trends;

(h) Review and issue reports on infection control risk assessment as required for construction/renovation projects;

(i) Review and approve the Infection Control and Exposure Control Plan policies and procedures and department-specific infection related policies annually;

(j) Keep apprised of regulatory guidelines/standards related to infection control.

(k) Respond to questions regarding techniques or policies of infection control throughout the organization; and,

(l) Develop or approve protocols, and recommends corrective actions for special infection control studies when indicated.

2.10-3 MEETINGS

The IC committee meets quarterly, with additional meetings called if necessary.

2.11 MEDICAL EDUCATION COMMITTEE

2.11-1 COMPOSITION

The Medical Education Committee will consist of, at a minimum, the Medical Director of Medical Education who will also act as the chair. The committee will include designated Clerkship Directors and any other participating preceptors. The committee members will be appointed by the Medical Executive Committee. In addition, representatives of the various nursing and allied health professions will participate on an as-needed basis. The Medical Education Committee is accountable to the Medical Executive Committee.

2.11-2 DUTIES

The Medical Education Committee shall establish written policies and procedures for the conduct of its business, including oversight of the medical students, interns, and residents in coordination with the University, College, or School of Medicine. The committee will ensure that the program operates in a structured manner according to the teaching policies of the affiliated University, College or School of Medicine. They will also provide oversight of the medical students, interns, and residents activities and progress in collaboration with the Instructors of Record. The Committee will also provide oversight of telemedicine conferencing, continuing medical education for the Medical Staff, and other programs as assigned. The Committee recommends the acquisition, purchase, or disposal of educational materials and assists in establishing rules and regulations for use of the medical library services by the members of the Medical Staff.

2.11-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair, ~~but at least quarterly~~. Meetings may be held in person or via electronic or e-mail communication. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee ~~and Board of Directors~~.

ARTICLE III

MEETINGS

3.1 AGENDA FOR REGULAR MEDICAL STAFF MEETINGS

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda may include the following:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) verbal or written administrative reports from the Chief of Staff, Departments, and committees, and the Chief Executive Officer;

(c) verbal or written reports by responsible officers, committees, and Departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;

(d) old business; and

(e) new business.

ARTICLE IV

PATIENT CARE

4.1 ADMISSION AND DISCHARGE OF PATIENTS

4.1-1 The Hospital will accept all patients for care and treatment to the extent it has appropriate facilities and qualified personnel available to provide necessary services or care. Accordingly, the Hospital will not accept patients for care and treatment with severe neurological trauma, severe and extensive third degree burns, and psychiatric patients with suicidal predilection. All physicians shall be governed by the official admitting policy of the Hospital. A patient can be admitted to the Hospital only by practitioners with admitting privileges.

4.1-2 A member of the Medical Staff with clinical privileges appropriate to the patient's needs shall be responsible for the medical care and treatment for each patient in the Hospital, for the prompt completion and accuracy of the medical record, for the necessary special instructions, and for transmitting reports of the condition of the patient to other members of the health care team and to relatives of the patient, subject to legal and privacy limitations. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record stating the date and time of such transfer.

4.1-3 A Conditions of Admission Form signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending Medical Staff member whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the member's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, specific consent that informs the patient of the nature of, and risks inherent in, any special treatment or surgical procedure shall be obtained.

4.1-4 Current medications being used by patients at the time of admission may be used on a continuing basis following admission providing that all such drugs be identified by the Hospital pharmacist and be in authorized identifiable pharmacy containers with appropriate labeling.

4.1-5 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. The admitting practitioner is responsible for informing Hospital administration and the nursing staff at the time of admission if the practitioner suspects the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The attending physician shall initiate any appropriate restrictions with respect to where in the Hospital the patient will be placed (i.e. isolated area for contagious disease) and shall recommend appropriate precautionary measures to protect the patient and others. In the event the patient or others cannot be appropriately protected, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed.

4.1-6 Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded

on the patient's chart as soon as possible after admission.

4.1-7 A patient admitted on an emergency basis who does not have a private physician may select any physician on the applicable service to attend to him. Where no such selection is made, the member of the Active, Incline Village, or Provisional Staff serving on-call for the appropriate service will be assigned to the patient and contacted by the emergency physician. The chiefs of each service shall provide a schedule for such assignments

4.1-8 Each member of the Medical Staff must assure continuing timely, adequate, professional care for patients under his/her care in the Hospital. Failure of an attending physician to meet these requirements may be a ground for corrective action under the Medical Staff Bylaws. A member of the Medical Staff who will be unavailable must, on the order sheet of the chart of each patient, indicate in writing, the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. It is the responsibility of the attending practitioner to make prior arrangements with the indicated practitioner, who must have privileges to provide appropriate continuing care.

4.1-9 In the event of a need to categorize admitting priorities in an emergency situation, the Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical Department and approved by the Medical Executive Committee.

4.1-10 As a routine basis for admitting, the admitting policies of the Hospital will be based on the following order of priorities:

(a) Emergency admissions

(b) Urgent admissions

(c) Pre-operative admissions

(d) Routine admissions

4.1-11 Patient transfer priorities shall be as follows:

(a) Emergency Department to appropriate bed.

(b) From obstetrical patient care area to general care area, when medically indicated.

(c) From Intensive Care Unit to general care area. No patient will be transferred from the ICU without such transfer being approved by the responsible physician.

4.1-12 For the protection of patients, the medical and nursing staffs and the Hospital, due to the lack of adequate facilities and personnel for the treatment of patients with serious mental illness and patients who may be dangerous to themselves and/or others, such patients shall be transferred to an appropriate facility when medically stable. When the transfer of such patients is not possible, the patient may be temporarily admitted to the general area of the Hospital with appropriate nursing and security supervision to allow for crisis intervention as available through community and Medical Staff clinical psychological/psychiatric services.

4.1-13 Any patient known or suspected to be suicidal or otherwise a danger to self, who is treated as a Hospital inpatient or through the Emergency Department should be offered a psychological or psychiatric consultation through available community and Medical Staff resources.

4.1-14 If any question as to the necessity of admission to, or discharge from the Intensive Care Unit

should arise, appropriate review of the decision is to be made by the Medical Director of the Intensive Care Unit in consultation with the attending physician.

4.1-15 The attending physician is required to document the need for continued hospitalization after specific periods of stay per disease categories as defined by the Medical Staff. This medical record documentation must contain:

(a) An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not considered sufficient.

(b) The estimated period of time the patient will need to remain in the Hospital.

(c) Plans for post-Hospital care.

4.1-16 The patient shall be discharged from the Hospital only on a written order of the attending Medical Staff member. If the patient indicates an intent to leave the hospital before the completion of treatment or contrary to the advice of the patient's attending practitioner, the nursing staff shall contact the patient's attending practitioner to arrange for the patient to discuss his or her plan with the attending practitioner before the patient leaves. The attending practitioner shall advise the patient of the implications of leaving the hospital against medical advice, including the risks involved and the benefits of remaining for treatment, and shall document this in the medical record. Should a patient insist upon leaving, the Hospital against the advice of the attending Medical Staff member or without proper discharge, a notation of the incident shall be made on the patient's medical record, and the patient shall be asked to sign the appropriate "Leaving Hospital Against Medical Advice" form acknowledging that they are leaving against medical advice and their understanding of the medical risks and possible consequences of refusing continued treatment at the hospital. If the patient cannot be located or refuses to sign the form, the nursing staff who witnessed the refusal shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

4.1-17 In the event of a hospital death, the deceased patient shall be pronounced dead by the attending physician or his/her designated covering physician within a reasonable period of time, or by a registered nurse who has been certified to pronounce a patient's death pursuant to the nursing standardized procedure. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease where the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of deceased patients shall conform to local law.

The patient's attending physician is responsible for notifying the next of kin in all cases of patient death and shall facilitate the reporting of patient deaths to the coroner or to other agencies as required by laws.

(a) If the basis for pronouncement of death is "brain death" (i.e. the total and irreversible cessation of all functions of the entire brain, including the brain stem), death must be pronounced by a physician, and a second, independent physician must confirm the determination of brain death. Both physicians must document their findings in the patient's record. The patient's family must be informed of the patient's death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, hospital administration shall be advised and consulted before medical interventions (e.g. respiratory) are discontinued.

(b) If the patient or the patient's family indicates that the patient has or will contribute anatomical gifts, the hospital protocol for identifying potential organ and tissue

donors shall be followed.

4.1-8 Except in the case of patients hospitalized less than 48 hours and in cases of normal obstetrical deliveries and normal newborn infants, in which case a final progress note may be substituted, a clinical resume discharge summary shall be written or dictated on all medical records of hospitalized patients.

4.2 AUTOPSIES

4.2-1 It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever appropriate, as described below, and consistent with applicable law. An autopsy may be performed only with a written authorization signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete autopsy protocol should be made a part of the deceased's medical record within 60 days. Autopsies are felt to be of particular value in the following circumstances and the Medical Staff is encouraged to actively seek family permission for autopsy for all in-patient deaths meeting these criteria:

(a) Deaths where there are significant questions related to the effectiveness of therapy.

(b) Deaths where there are significant questions relating to the extent of disease.

(c) Deaths where ante mortem diagnostic procedures have resulted in unusual or unexplained findings.

(d) Deaths where genetic diseases are suspected but not confirmed prior to death. An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy costs.

An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy rates.

4.3 MEDICAL RECORDS

4.3-1 The attending Medical Staff member shall be responsible for the complete and legible medical record for each patient. Its contents shall be pertinent and current. The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services, its contents shall be pertinent and current. The inpatient record shall have appropriate identification data; including, but not limited to:

(a) Chief complaint resulting in admission

(b) History of present illness

(c) Personal and family history

(d) Applicable systems review

(e) Physical examination

(f) Special reports such as consultation, clinical laboratory and radiology services

(g) Provisional diagnosis

(h) Medical or surgical treatment

(i) Operative reports, when appropriate

(j) Pathological finding, when appropriate

(k) Progress notes

(l) Final diagnosis

(m) Condition on discharge

(n) Summarizing clinical resume

(o) Autopsy report when performed

(p) Procedural, therapeutic, and operative consents when appropriate

(q) Post-discharge follow-up plans and medications

4.3-2 All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by signature. Clinical entries may be counter signed by physicians caring for the same patient.

4.3-3 The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission, but an interval admission note must be written at the time of admission that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.4 HISTORY AND PHYSICAL

4.4.1 A complete admission history and physical examination shall be completed no more than 30 days before or 24 hours after admission, and it must be recorded in the patient's medical record within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history and physical examination has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports the report may be used in lieu of the admission history and report of the physical examination report, provided that an appropriate assessment is performed, including a physical examination within the previous 24 hours to update any components of the patient's medical status that may have changed since the earlier history and physical or to address any areas where more current data is needed. In such instances, a physician or other practitioner qualified to perform the history and physical writes an interval admission note addressing the patient's current status and/or any changes to such status, which includes all additions to the history and any subsequent changes in the physical findings. This update examination must be completed and documented in the patient's medical record by an appropriately qualified and privileged member of the Medical Staff within 24 hours after admission. If the history and physical that was performed prior to the patient's admission is determined to be incomplete, inaccurate or otherwise unacceptable, the physician responsible for the update examination may disregard the existing history and

physical, and perform a new history and physical. Any such history and physical must be completed and documented in a timely manner, as described these Rules these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded at the time of admission. All such outside records of histories and physicals shall be on a form approved by the Hospital and compatible with the current medical record system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the Hospital's medical record.

4.4-2 When a patient is readmitted to the Hospital within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available in a unit record.

4.4-3 When a patient is admitted for a hospitalization under 48 hours, a Short Stay History and Physical form may be used in lieu of a regular history and physical format. On patients admitted from the emergency room for a short stay, the emergency room record will be deemed sufficient, provided that it is complete and contains at least the same information as indicated necessary on the Short Stay History and Physical form.

4.4-4 The medical record system utilized by the Hospital shall be a unit record system.

4.4-5 When a history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending physician states in writing that such delay would be detrimental to the patient. However, this requirement shall not preclude rendering emergency medical or surgical care to a patient in dire circumstances, as documented by the attending physician.

4.4-6 The attending physician shall authenticate by countersignature the history, physical examination and preoperative note when they have been recorded by an authorized allied health professional, a medical student, or resident staff physician from an outside educational institution performing preceptorship at the Hospital.

4.4-7 The history and physical examination may be performed and documented by any physician permitted by law as long as a physician who is currently a member of the Medical Staff, with privileges to perform a history and physical examination, updates the history and physical examination consistent with these Rules and Regulations. This shall include at least the following:

a. Review of the history and physical examination document;
b. Determination that the information is compliant with the hospital's defined content requirements for history and physical examinations;
c. Obtaining missing information through further assessment as needed;
d. Update information and findings as necessary:
    1. Inclusion of absent or incomplete required information;
    2. A description of the patient's condition and course of care since the history and physical examination was performed;
    3. A signature, date and time on any document with updated or revised information as an attestation that it is current.

The history and physical examination must have been performed within thirty days prior to the patient's admission to the hospital and the update must be completed and documented in the patient's medical record within 24 hours of admission and on the day of any outpatient surgical procedure.

4.5 PROGRESS NOTES

4.5-1 Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written daily on all acute care patients. In addition, appropriate progress notes shall be written at least every week on swing bed patients.

4.6 OPERATIVE NOTE

4.6-1 Complete operative reports shall be dictated or written immediately after surgery, specifying the surgeon, procedure, diagnosis, anesthesia, and pertinent findings. The complete operative report shall include, but not be limited to:

(a) Surgeons, assistant surgeons, and anesthesiologist

(b) Type of anesthesia

(c) Detailed procedural account

(d) Any remarkable or unusual findings

(e) Complications

(f) Tissue removal and disposition

(g) Drains, appliances, or prostheses used

(h) Post-op condition

(i) Disposition from the operating room

4.7 CONSULTATIONS

4.7-1 Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of the consultation. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the record, be recorded prior to the operation. Consultations must be signed by the consultant.

4.7-2 Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.

4.7-3 The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rest with the practitioner responsible for the care of the patient. Except in cases of emergency, when time does not permit, consultation should be obtained in the following situations:

(a) when the patient is not a good risk for operation or treatment;

(b) when the diagnosis is obscure after ordinary diagnostic procedures have been

completed;

(c) where there is doubt as to the choice of therapeutic measures to be utilized;

(d) in unusually complicated situations where specific skills of other practitioners may be needed;

(e) in instances in which the patient exhibits severe psychiatric symptoms; and

(f) when requested by the patient or his/her family.

4.7-4 Appropriate pediatric consultation in the wards should be considered for sick children under the following circumstances:

(a) A prolonged hospitalization if a child is involved with potential medical pediatric problems (e.g., multiple trauma, septic orthopedic problems, acute burns).

(b) Infectious problems of a life threatening nature (e.g., epiglotitis, meningitis).

(c) Other problems involving intensive care hospitalization (e.g., diabetes, ketoacidosis, and status asthmaticus).

(d) All patients admitted for surgical procedures less than two years of age.

4.7-5 The attending Medical Staff member should request consultations when the patient would seemingly benefit by the additional skills or abilities of other practitioners. The attending Medical Staff member is responsible for directly requesting the consultant to assist and he/she shall provide written authorization to permit another practitioner to attend or examine the patient, except in an emergency. The attending physician shall document the order for the consultant in the Physician Orders section and also indicate of the reason for the consultation on the Physician Orders section or Progress Notes in the patient's medical record. A consultation has not been fully requested or authorized unless the attending Medical Staff member has personally contacted the consultant or the consultant's office and the attending member has written a note in the chart. No practitioner is obligated to accept any request for consultation.

4.7-6 If a nurse or licensed registered pharmacist has any reason to doubt or question the care provided to any patient or believes appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the nursing supervisor who in turn may refer the matter to the Nursing Executive. The Nursing Executive may bring the matter to the attention of the chief of the Department where the practitioner has privileges. Where circumstances are such to justify such action, the chief of the Department may himself/herself request the consultation.

4.8 ABBREVIATIONS

4.8-1 Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of unapproved abbreviations shall be kept on file in the Medical Record Department.

4.8-2 Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and timed, dated and signed by the responsible Medical Staff member at the time of discharge of all patients.

4.9 CONSENTS

4.9-1 Unless otherwise authorized by law, written authorization of the patient, guardian or other legally authorized individual is required for release of medical information to persons not otherwise authorized to receive this information.

4.10 REMOVAL AND ACCESS OF MEDICAL RECORDS: CONFIDENTIALITY

4.10-1 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without the written approval of the Chief Executive Officer. Unauthorized removal of charts from the Hospital is grounds for corrective action, to be determined by the Medical Executive Committee of the Medical Staff.

4.10-2 In case of re-admission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or another.

4.10-3 Access to medical records may be afforded to members of the Medical Staff for a bona fide study and research consistent with preserving the confidentiality of professional individually-identifiable information concerning the individual patients. All such projects and access shall be approved by a duly constituted Institutional Review Committee in accordance with applicable state and federal law, including the HIPAA Privacy Regulations. Approval must also be obtained from the Medical Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, and in accordance with applicable laws, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering the periods during which they attended such patients in the Hospital.

4.10-4 A medical record shall not be permanently filed until it is completed by the responsible Medical Staff member or is ordered filed by the Medical Executive Committee in the event that the Medical Staff member is permanently unable to sign.

4.11 ORDERS

4.11-1 A Medical Staff member's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the Medical Staff member. All pre-printed orders shall be reviewed annually by the Medical Executive Committee for appropriateness.

4.12 MEDICAL RECORD DELINQUENCY

4.12-1 The patient's medical records shall be completed at the time of discharge, or in no event later than 14 days following discharge. This will include progress notes, final diagnosis, and a dictated clinical resume. If the record still remains incomplete 15 days after discharge, the Medical Records Manager shall notify the Medical Staff member by certified, receipted mail that his/her privileges to admit or attend patients shall be suspended 7 days from the date of notice, and such Medical Staff members shall remain suspended until the records have been completed. The admitting office shall be notified of this action. Ongoing care of patients already in the Hospital may be continued. The suspended member shall not care for any patients other than those currently admitted under his/her own name and may not provide consults on Hospital or emergency room patients. If the suspended member is on call, he/she is responsible for finding another physician to see any patients requiring care while he/she is on call. Suspension of admitting privileges does not affect the Medical Staff member's

privilege to provide patient care in emergency circumstances when the suspended member is the only provider available to provide that necessary care. Any member whose privileges have been suspended for failure to complete medical records in a timely fashion for a total of thirty (30) days or longer in a twelve (12) month period may be reported to the Medical Board of California by the Chief Executive Officer, pursuant to California Business and Professions Code section 805 and the National Practitioner Data Bank.

4.13 LONG TERM CARE

4.13-1 Physicians must visit their Long Term Care residents as needed and at least every 30 days unless there is an alternate schedule. Any change of condition must be documented in the progress notes. Progress notes and orders must be signed and dated at the time of the visit. Histories and physicals must be updated yearly. Histories and Physicals for residents, and updated Histories and Physicals for residents returning to ECC from Acute must be completed within 48 hours of admission to ECC. Failure to comply with the above constitutes a deficiency. Physicians will be notified by the Extended Care Center Director of Nursing, in writing, of any Extended Care Center record deficiencies. address the matter as warranted. A suspension may be imposed pending correction of the deficiency.

4.14 VERBAL AND WRITTEN ORDERS

4.14-1 All orders for treatment shall be in writing. Verbal orders are to be used infrequently. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom the orders were dictated, with the name of the ordering practitioner per his/her own name noted. The date and time the orders were received shall also be noted. The responsible prescriber or another practitioner who is responsible for the care of the patient and is authorized to write orders shall authenticate such orders by signature, date and time, within 48 hours. Duly authorized persons who may receive verbal orders or telephone orders for orders within their scope of practice are licensed registered nurses, licensed vocational nurses, occupational therapists, speech therapists, pharmacists, laboratory technologists, respiratory therapists, physical therapists, and medical nutritional therapists.

4.14-2 A practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

4.14-3 All previous orders are cancelled when patients are transferred to surgery.

4.14-4 A qualified full-time, part time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. The radiologist or other practitioner who performs radiology services including nuclear medicine must sign reports of his or her own interpretations.

4.14-5 Radiology Services must be provided only on the order of practitioners with clinical privileges or, consistent with State Law, other practitioners authorized by the medical staff and the governing body to order the services.

4.15 GENERAL RULES REGARDING SURGICAL CARE

4.15-1 All surgical patients must receive a pre-operative study so that an accurate diagnostic impression as well as an estimated operative risk to the patient can be clearly established prior to proceeding with the surgical treatment.

4.15-2 Surgeons must be in the operating room and ready to commence operations at the time

scheduled. As the anesthesiologist will not administer anesthesia until the surgeon is present or is in the immediate area, the surgeon should arrive at least 10 minutes before the scheduled surgery. Repeated tardiness problems shall be handled by the Chair of Surgery and/or the OR supervisor and may result in the temporary restriction of scheduling privileges.

4.15-3 Surgery scheduling:

(a) Surgery shall be scheduled on the following priority situations:

(1) Emergency:

(a) Acute life threatening situation.

(b) Acute sensory or limb threatening situation - surgery must begin with all deliberate speed.

(2) Urgency: Sub acute situation where undue delay will produce irreversible damage. Surgery will begin at the earliest available time appropriate for the degree of urgency.

(3) Elective: Chronic, relapsing, or volitional situations where postponement would create no undue risk or hardship. Surgery is scheduled at a time mutually convenient for the patient, surgeon, and Hospital.

(b) Priority scheduling should appropriately reflect the patient's situation and not reflect the surgeon's situation. Abuse of priority scheduling may result in restriction or suspension of OR privileges.

4.15-4 The medical record must document a thorough physical examination prior to the performance of surgery. When the history and physical examination is not recorded prior to the time stated for the operation, the patient will not be taken into the surgical suite.

4.15-5 Except in severe emergencies, the pre-operative diagnosis and laboratory tests must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, there must be adequate documentation. In any emergency, the physician shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

4.15-6 All anatomical parts, foreign objects and tissues removed at the operation shall be sent to the Hospital pathologist for examination excluding teeth. The pathologist's authenticated report shall be made a part of the patient's medical record.

4.15-7 All tissues of potential diagnostic value removed in the Emergency Department shall be sent to the Hospital pathologist for examination. Other tissues, such as fragments from debridement of wounds, foreign bodies, etc., removed in the Emergency Department shall be submitted to the Hospital pathologist at the discretion of the physician performing the removal excluding teeth.

4.15-8 Written and signed surgical consents shall be obtained prior to the operative procedure except in situations wherein the patient's life is in jeopardy, when suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a temporarily or permanently incompetent adult or minor for whom consent for surgery cannot be immediately obtained, the circumstances should be fully explained in the patient's medical record.

4.15-9 The surgeon should exercise professional judgment in selecting an assistant who is capable of safely concluding the procedure if necessary.

4.15-10 Oral and maxillofacial surgeons may admit and perform history and physical examinations without supervision as long as they provide documentation of training and experience and are granted the clinical privilege to do so. Otherwise, a patient admitted for dental or podiatric care is a dual responsibility involving the dentist and/or podiatrist and a physician member of the Medical Staff.

(a) Dentist and podiatrist responsibilities:

(1) A detailed dental and/or podiatric history justifying the Hospital admission.

(2) A detailed description of the examination of the oral cavity/lower extremity and a pre-operative diagnosis.

(3) A complete operative report, describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissues with the exception of teeth and fragments shall be sent to the Hospital pathologist for examination.

(4) Progress notes pertinent to the oral/podiatric condition.

(5) Clinical resume statement at the time of discharge.

(b) Physician's responsibilities:

(1) A medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general medical status while hospitalized.

(c) The discharge of patients shall be on written order of the dentist and/or podiatrist member of the Medical Staff with the written concurrence of the attending physician involved.

4.15-11 Operations shall be scheduled through the surgical services office, or with the appropriate nursing shift supervisor. A surgical log shall be maintained for the scheduling of all surgeries. The surgical assistant, if required, shall be stated at the time surgery is scheduled.

4.15-12 For all outpatient surgical cases, local post-operative coverage will be provided by the attending Medical Staff member or by an alternate Medical Staff member by pre-arrangement.

4.15-13 A complete admission history and physician examination shall be recorded within 24-hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports may be used In lieu of the admission history and report of the physician examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within 24 hours prior to commencing the surgery. All such outside records shall be on a form approved by the

Hospital and compatible with the current medical records system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the hospital's medical records.

4.16 GENERAL RULES REGARDING ANESTHESIA CARE

4.16-1 A pre anesthesia evaluation (is documented) by an individual qualified to administer anesthesia performed within 48 hours prior to surgery. Anesthesia is defined as general, regional, or MAC. The pre anesthesia evaluation documentation must include the following:

- 4.16-1.1 A patient interview to assess medical history, anesthetic history and medication history, and allergy history, including anesthesia risk.
- 4.16-1.2 An appropriate physician exam that includes, at a minimum airway assessment, a pulmonary exam to include auscultation of the lungs, and a cardiovascular exam.
- 4.16-1.3 Review of objective diagnostic data.
- 4.16.1-4 Assignment of ASA physical status.
- 4.16.1-5 The anesthesia plan and discussion of risks and benefits of the plan with the patient or the patient's legal representative.
- 4.16.1-6 Assessment of pain management using visual scale of zero to ten or the "FACES" tool for children.

4.16-2 There is an intra-operative Anesthesia Record. This record accurately reflects critical techniques, management, and patient responses including condition at the end of the anesthetic. The intra operative anesthesia record must include the following time-based record of events.

- 4.16-2.1 Immediate review prior to initiation of anesthetic procedures including patient re-evaluation and a check of equipment, drugs and gas supply.
- 4.16-2.2 Monitoring of the patient.
- 4.16-2.3 Amounts of drugs and agents used, and times of administration.
- 4.16-2.4 The types and amounts of intravenous fluids used, including blood and blood products, and times of administration.
- 4.16-2.5 The techniques used.
- 4.16-2.6 Unusual events during the administration of anesthesia.
- 4.16-2.7 The status of the patient at the conclusion of anesthesia.

4.**16-3** With respect to inpatients, a postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. For the outpatient surgical patient, this post anesthesia assessment must be done prior to discharge from the facility. At a minimum, the post anesthesia assessment follow up report documents the following:

- 4.16-3.1 Cardiopulmonary status.
- 4.16-3.2 Level of consciousness.
- 4.16-3.3 Any follow up care and/or observations, and patient instructions.
- 4.16-3-4 Any complications occurring during post-anesthesia recovery.

4.17 GENERAL RULES REGARDING HOME CARE

4.17-1 Patients requiring home care services shall have a written order from the attending physician. Such orders shall be reviewed at least every sixty (60) days.

4.17-2 Treatment plans shall be signed by the physician no later than thirty (30) days after initiation of service.

4.18 GENERAL RULES REGARDING EMERGENCY CARE

4.18-1 All patients who present to the Emergency Department of either Tahoe Forest Hospital or IVCH shall be given a medical screening examination by an Emergency Department physician. Patients determined to have an emergency medical condition shall be given such stabilizing treatment as necessary within the capabilities of the facility, including consultation and treatment by specialty physicians if applicable. Any discharge or transfer of emergency patients shall be done in accordance with the Hospital's policy regarding the treatment and transfer of emergency patients. Such policy shall be in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Classifications of staff who may conduct medical screening examinations in accordance with EMTALA shall include: (a) in the Emergency Department, licensed physicians in accordance with their privileges; and (b) in the Women and Family Center, licensed physicians in accordance with their privileges and registered nurses who have been approved to perform such examinations based on demonstrated competence and action pursuant to approved standardized procedures.

4.18-2 Medical Staff members shall provide call coverage according to schedules drawn up by the IVCH Medical Director for IVCH and by the Chiefs of the Anesthesia, Medicine, Ob/Pediatrics and Surgical Departments for Tahoe Forest Hospital District.

4.18-3 A physician on call, upon being called for an acute emergency patient, must respond within 30 minutes.

4.18-4 Should a difference of opinion exist between the referring emergency physician and the on-call doctor as to patient management and disposition, the emergency physician, being physically present and responsible for the patient's care, shall direct the immediate patient management. Decisions shall primarily reflect what is best for the patient. When resolutions of the differing opinions are not immediately achieved and the on-call specialist continues to disagree on the need for his/her treatment, the emergency doctor may:

(a) Contact the relevant Department chairperson for assistance in resolving the matter or,

(b) Call another appropriate physician from the on-call roster.

Issues raised by the conflicting opinions shall be discussed at the next Departmental meeting with additional referral to the Medical Executive Committee as needed.

4.18-5 Any on-call Medical Staff member who fails to respond in a timely manner or who refuses to consult on and attend an emergency patient at the request of the Emergency Department physician shall be subject to corrective action by the Medical Executive Committee, in accordance with the Medical Staff Bylaws.

4.18-6 Out of town practitioners who are not members of the Medical Staff shall not use the Emergency Department to care for any patients, friends or relatives. All practitioners wishing to utilize the Emergency Department must submit applications and satisfy all other requirements for staff privileges as stated in the Medical Staff Bylaws and these Rules.

4.18-7 An appropriate medical record shall be kept for every patient receiving emergency service and this record shall be incorporated into the patient's records, if such exists. The records shall include:

(a) Adequate patient information.

(b) Information concerning the time of the patient's arrival.

(c) Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his arrival at the Hospital.

(d) Description of significant clinical, laboratory, and radiographic findings.

(e) Diagnosis.

(f) Treatment given.

(g) Condition of the patient on discharge or transfer.

(h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

(I) Method of arrival.

4.18-8 Each patient's medical record shall be signed by the physician in attendance who is responsible for its clinical accuracy.

4.19 Rehabilitative Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology)

4.19-1 Rehabilitative Services must be provided by individuals who are licensed as specified in the California Business & Professions Code for the functions to be performed. A licensed physical therapist, occupational therapist or speech therapist may be authorized by the Medical Staff, through the process described in the Allied Health Professional Manual, to hold and exercise such privileges as are consistent with the scope of his or her license and the hospital licensing laws. These privileges shall include, but not necessarily be limited to, the authority to receive and implement orders as described below.

4.19-2 Rehabilitative Services must be furnished in accordance with a written plan of treatment, and in accordance with the orders of duly authorized practitioners. The orders must be incorporated in the patient's medical record.

4.19-3 The initial order for Rehabilitative Services must be issued in writing by a physician, who shall retain overall responsibility for the patient's care. The order should state the reasons for the referral, and may specify: "Evaluate patient, develop a plan of care, and implement plan." It may also be more limited in scope or more detailed, at the discretion of the physician. It may not state, simply: "Evaluate and treat." Pre-printed orders may be approved by the Medical Executive Committee to enhance the efficiency of the ordering process.

4.19-4 If the physician's order provides for the therapist to develop and implement a plan of care, the therapist shall document the plan in the medical record, and shall collaborate with the physician before the plan is implemented or modified. The documented plan shall include the type, amount, frequency and duration of the service to be provided, and indicate the diagnosis and anticipated goals. The physician's approval of the plan or modification, which may be conveyed orally while collaborating with the therapist, shall be documented by the therapist in the medical record.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Judy Newland
COO

DATE: 9-8-2016

ISSUE:

To protect the health and safety of employees, patients, and the community as a whole the medical staff is approving a policy that ensures that current Medical and Allied Health Staff are immune to vaccine preventable diseases and follow the Centers for Disease Control (CDC) and California Department of Public Health (CDPH) recommendations for vaccine administration to healthcare personnel. The TFHD Professional Courtesy Policy establishes guidelines for the extension of professional courtesy discounts for Physicians and Allied Health Staff for the purpose of immunizations.

BACKGROUND:

Following exposure to measles patients by the medical staff, it was identified that there is no documentation status of immunizations for Medical and Allied Health Staff within the Health System. Currently there is no requirements at time of credentialing for medical staff applicants to provide immunization status as recommended by the CDC and CDPH. The medical staff is approving an Immunizations/Vaccinations for Medical and Allied Health Staff Policy to ensure immunizations are documented at time of credentialing and all current Medical and Allied Health staff are current with their immunizations. To support Medical and Allied Health Staff on getting current on immunizations/vaccinations, a professional courtesy discount is being recommended.

ACTION REQUESTED:

Approve the TFHD Professional Courtesy Policy. The Non-Monetary Compensation policy is available to use as an alternative to support Medical and Allied Health Staff obtaining current immunization status.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Department:	*Board - ABD*
Applies To:	*System*

TFHD Professional Courtesy Policy

PURPOSE:

Purpose: The purpose is to establish guidelines for the extension of professional courtesy discounts to Physicians and Allied Heath Professionals Staff for the purpose of Immunizations.

A. Tahoe Forest Health System(TFHS) will offer no-cost immunizations to credentialed Physicians and Allied Health Staff, where permitted by Stark regulations.

B. TFHS will offer discounts on bills for immunizations to credentialed Physicians and Allied Health Staff, who are not employees of an Affiliate or TFHS, only as permitted by this policy.

C. Any discounts offered or provided pursuant to this policy comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law.

D. Under no circumstances will any discount involve a TFHS paying remuneration to a physician or any other individual or entity, directly or indirectly, with the intent to induce the physician or other individual or entity to refer patients to, or otherwise generate business for, TFHS.

POLICY:

Definitions:

A. **"Remuneration"** means anything of value, including, but not limited to, cash, items or services.

B. **"Physician"** means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.

C. **"Other potential referral source"** means an Allied Health Staff (AHS) and any individual [other than a licensed physician, dentist, chiropractor, optometrist or podiatrist] or entity in a position to make or influence referrals to, or otherwise generate business for, a provider.

D. **Professional Courtesy discount is:** the provision of free or discounted health care items or services to physician or allied health staff

E. **“Immunizations”** means:

1. routine screening and immunizations for Hepatitis B, influenza (annual flu shots) and TB screening;
2. other screening and immunizations necessary due to exposure a dangerous virus or disease while providing physician/AHS services at a Provider; and
3. screening and immunizations for MMR, Varicella and Tdap;

Policy:

A. The Professional Courtesy Policy must be approved by the Tahoe Forest Health District governing board prior to offering the discount.

B. This policy applies to the TFHS which includes following entities of Tahoe Forest Hospital District (the "District") with a formal medical staff: (1) Tahoe Forest Hospital and Incline Village Community Hospital (each, an "Affiliate"); and (2) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Provider").

C. Immunizations described in Definitions E.1 and E.2 above may be offered at no cost to physicians and AHS, as permitted by Stark regulations. These Immunizations are not considered to be provided at a discount.

D. TFHS and Affiliates with a formal medical staff may offer a discount on Immunizations described in Definitions E.3 above, to physicians and Allied Health Staff, provided that it follows all the steps set forth in this policy and the discount is offered without regard to the volume or value of referrals or other business generated between the parties. Unless permitted by this policy, Affiliates or Providers may not offer or provide discounts to any other potential referral source.

E. The discount on Immunizations described in Definitions E 3 above will be 100%.

F. The discount on Immunizations described in Definitions E.3 are the only discounts that can be offered on services provided to physicians and AHS.

G. Discounts may not be offered pursuant to this policy to any individual who is a federal health care program beneficiary, e.g., Medicare or Medi-Cal/Medicaid.

H. TFHS elects to offer discounts permitted by this policy, the TFHS and its Affiliates is required to offer discounts to all current members of its medical and Allied Health Staffs.

I. Physicians not eligible for Immunizations as a courtesy discount defined in Definitions E.3 above, may receive the Immunizations, with the value of the services tracked as part the District's Non-Monetary Compensation policy. The value of the Immunizations shall be the acquisition cost of the vaccine/ screening test incurred by the District.

J. TFHS shall advise all eligible individuals of the availability of and limitations on the discounts set forth in this policy. Notification may be made in person, in writing, or other form of private communication.

K. TFHS will implement a procedure for approving in writing all discounts offered and provided to individual pursuant to this policy.

L. The Affiliate's or TFHS COO is responsible for ensuring that all individuals adhere to the requirements of this policy. If the COO identifies a violation of this policy, the COO shall immediately report the violation to the District's Compliance Officer.

M. Adherence to this policy shall be monitored as part of the District's Corporate Compliance Annual Work-plan.screening and immunizations for MMR, Varicella and Tdap;

PROCEDURE:

Special Instructions / Definitions:

Related Policies/Forms:AGOV1502 Physician Non-Monitеary Compensation, ABD-09 Financial Assistance Program Full Charity Care and Discount Partial Charity Care

References:Ref: CDPH Immunizations and Immunity Testing Recommendations for California Healthcare Personnel and Health Science Students 2015

All revision dates:

Attachments:

No Attachments

Approval Signatures

Committee	Approver	Date
	Harry Weis: CEO	pending

MEMORANDUM OF UNDERSTANDING

Between

TAHOE FOREST HOSPITAL DISTRICT

EMPLOYEES' ASSOCIATION of PROFESSIONALS

And The

TAHOE FOREST HOSPITAL DISTRICT

July 1, 2016 to June 30, 2019

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ARTICLE 1. Preamble

1.1. The Tahoe Forest Hospital District, herein referred to as "the District" and the Tahoe Forest Hospital District Employees' Association of Professionals, herein referred to as "the E.A.P.", having met and conferred in good faith within the meaning of the Meyers-Milias-Brown Act (California Government Code Section 3500 et seq.) have entered into this Memorandum of Understanding.

1.2. It is the intent of the parties to set forth the basic agreement covering rates of pay, hours of work and conditions of employment between the parties.

ARTICLE 2. Recognition

2.1. The District recognizes the E.A.P. as the exclusive representative for employees covered by this Memorandum of Understanding whose job titles are listed in Appendix A for the purpose of meeting and conferring with respect to rates of pay, hours and working conditions.

ARTICLE 3. Management Rights

3.1. It is acknowledged that the District has, except as otherwise limited by this Agreement and/or applicable law, retained the right to determine the nature and extent of services to be performed as well as the right to determine and implement its public function and responsibility, determine the mission of its constituents department, manage and control all property, facilities and operations, maintain the efficiency of governmental operations, take all necessary actions to carry out its mission in emergencies, and take such other and further action as may be necessary to organize and operate the District in an efficient and economical manner consistent with the best interests of the public it serves.

3.2. It is agreed that the District, except as otherwise limited by this Agreement and/or applicable law, have and retain all of the customary and usual rights, powers, functions, and authority to discharge its obligations including those described within its then-current employer-employee relations ordinance or afforded under the Meyers-Milias-Brown Act, the Local Health Care District Law, or other applicable law.

3.3. The parties further agree that, except as otherwise limited by this Agreement, and/or applicable law, the District shall retain the right to hire, evaluate, promote, layoff, discipline, discharge, set work schedules, make work assignments, and otherwise direct and control its operations consistent with its public purpose. The District may make such reasonable rules and regulations, not in conflict with this Agreement or its obligations to the E.A.P. under applicable law, as it may from time to time deem appropriate for the purpose of maintaining order, safety and/or effective operation of its facilities.

ARTICLE 4. Employee Rights

4.1. The right of employees to form, join, and participate in the activities of Employee Associations or employee Organizations of their own choosing for the purpose of representation on all matters of employment relations. (Cal. Govt. Code §3502)

4.2. The right of employees to refuse to join or participate in the activities of Employee Associations or Employee Organizations.

4.3. The right of employees to be free from interference, intimidation, restraint, coercion or discrimination by an Employee Association or Organization and/or by the District because of the employee's exercise of his/her rights under Section §3502 of the California Government Code. (Cal. Govt...Code §3506)

4.4. The Employee Association of Professionals has the right, upon its request and prior to adoption by the District, to meet with the District to discuss proposed changes to matters within the scope of representation set forth in California Government Code Section §3504, except in emergencies. (Cal. Govt. Code §3506)

4.5. Organizational Security: It shall be a condition of continued employment that on or after the thirtieth (30th) day following the beginning of employment or the effective date of the Agreement to begin organizational security, whichever is later, each employee covered by this Agreement shall either:

4.6. Be a member of the Association, or

Pay to the Association a fair share agency fee equal to the monthly periodic dues of the regular membership, less costs which are not related to the administration of this Agreement and the representation of employees; provided, however, that each employee will have available to him/her membership in the Union on the same terms and conditions as are available to every other member of the Association; or

Execute a written declaration that the employee is a member of a bona fide religion, body, or sect which holds a conscientious objection to joining or financially supporting any public employee organization as a condition of employment; and

Pay a sum equal to the agency fee described in a.2 to a non-religious, non-labor charitable fund chosen by the employee. The employee shall furnish written proof to the Hospital and the Association that this contribution has been made.

4.7. Dues Deductions: The Association shall have sole and exclusive right to have membership dues or agency fees deducted, by the Hospital, from bargaining unit members. The Hospital, upon appropriate written authorization from any bargaining unit member shall deduct from each paycheck, from the wages, due and payable to those employees who authorize the Hospital in writing to do so, half of the regular monthly dues or agency fee. All monies so deducted by the Hospital shall be forwarded to the Association by the Hospital as promptly as may be consistent with the Hospital's accounting procedures but in no event later than fifteen (15) days from when these monies were deducted.

4.8. The written authorization for Association dues deductions shall remain in full force and effect during the life of the Agreement between the Hospital and the Association unless canceled in writing by the employee and provided to the Association.

ARTICLE 5. Definitions

5.1. When referred to in the contract, the following definitions apply:

Date of hire: Date of hire is defined as the date on which an employee is officially the first paid and worked day at the District.

Continuous service: Continuous service is defined as the employee's continuous employment by the District less any unpaid absences from work in excess of thirty (30) calendar days.

Department member: An employee who has been hired into a posted position as documented on a Personnel Action Form, participates in department meetings and trainings and maintains documented competencies in the department and has completed initial probationary period.

Lump Sum: Lump sum payment calculations will be based on wages paid in the calendar year prior to the date of disbursement. Cancelled standby and holiday pay are included in the lump sum. The calculation for holiday pay is the number of holiday hours worked in the calendar year multiplied by current regular base rate. Calculations exclude over time, double time, callback, MOU education, nonproductive, standby, holiday standby or other premium pay.

Additional shift: a shift added to an employees work schedule after schedule has been posted.

Base pay: Pay received for a given work period, such as an hour or week, not including additional compensation such as shift differential, per diem differential, overtime, bonus or other payments.

Charge Nurse/Team Leader: in addition to providing patient care, collaborates with all members of the interdisciplinary team to ensure patient needs are met during a shift when three or more nurses are working.

Weekend: Where an employee is required to work a certain number of weekend shifts, “weekend” shall include shifts scheduled to begin between 7:00 pm Friday and 6:59 pm on Sunday. Start times shall be based on scheduled, as opposed to actual, start times. Employees who clock in or begin working prior to a scheduled shift start time shall not be considered to be working a weekend shift unless the shift would be considered “weekend” according it its scheduled start time. This article shall not affect the definition of “weekend” for shift differential purposes.

Job classification: In the event of layoffs employees in like job classification (such as RN, CLS, DI Tech) will be considered by classification, not job title.

Job title: A specific name given to a particular job which is used to distinguish that job from other jobs within the organization.

Qualified Employee: An employee who meets the minimum qualifications of a job description.

ARTICLE 6. Employee Status

6.1. All District employees shall be classified as one of the following listed below. If an employee's hours are reduced as a result of cancel days because of low patient census, the employee's status will not be affected.

6.2. Full Time: A person who is scheduled for 12 hour shifts and works seventy-two (72) hours in a two (2) week pay period.

6.2.1. A person who is scheduled for 8 or 10 hour shifts and works 80 hours in a two week pay period.

6.2.2. A night shifts employee who is regularly scheduled for 10 hour shifts and works at least 70 hours in a two week pay period.

6.3. Regular Part Time: A person who is scheduled for, and regularly works, at least forty eight (48) and up to seventy one (71) hours in a two (2) week pay period. It is the expectation that regular part time employees will flex up to full time based on department needs.

6.4. The District will make every effort to increase work hours for regular part time employees hired prior to December 1, 2013 to meet the 48-hour requirement. If the District is unable to increase work hours to 48 in a payperiod, regular part time employees hired prior to December 1, 2013 regularly scheduled for 40 hours a payperiod will be considered as regular part time.

6.5. Short Hour: Regularly assigned to work a predetermined work schedule of less than 20 hours per week or less than forty (40) hours per pay period.

6.6. Per Diem: A person who is scheduled to work based on the needs of the District and who must be available five (5) shifts per four (4) week schedule. Two (2) shifts must be weekends and two (2) must be night shifts.

6.6.1. Per Diem employees must be available to be scheduled on Thanksgiving, Christmas Eve, Christmas Day, New Year's Eve, New Year's Day and July 4th. Every Per Diem employee is required to work at least one of these holidays on a rotational basis.

6.7. Casual Part Time: Employee works on an intermittent and as needed basis.

6.8. Temporary: A person who is hired to fill a temporary need for additional staff for a period of time up to one year.

6.9. Seasonal: A person who is hired to work during a defined period of time to supplement department staff during high census periods. Defined period of time may not exceed 180 days.

6.10. The District may enter into an agreement with employees to job share.

ARTICLE 7. Wages

7.1. Wages have been set according to classification pursuant to policies fixed by and between the District and the E.A.P. No changes in this MOU provision can be made without the consent of both parties in writing.

7.2. The wage scales set forth are intended to constitute minimum scales only, and nothing in this Memorandum of Understanding shall preclude the District from paying in excess of such minimum rates subject to the meet and consult process. Wage scales for employees participating in training programs may be set at a lower wage by mutual agreement of the District and the E.A.P.

7.3. Effective with the pay period containing July 1, 2016 full time, part time, short hour employees in job titles identified in Appendix A will receive the greater of a two and one-half (2.5%) increase to base pay or the market adjustment to the position; however, employees will not be increased beyond the maximum of the salary range.

7.4. Effective with the pay period containing July 1, 2017 and 2018 full time, part time, short hour employees in job titles identified in Appendix A will receive the greater of a two (2%) increase to base pay or the market adjustment to the position; however, employees will not be increased beyond the maximum of the salary range.

7.5. Those who reach the maximum will receive a lump sum adjustment for the total value of the increase that applies to the job position. Any employee who is over the top of the new range will be red-circled (remain at the current rate until the range maximum catches up to that amount) but will still receive a lump sum equivalent to the amount indicated in article 7.3 and 7.4 respectively, or the market adjustment for that position.

7.6. Range chart is structured at thirty (30) % span with two and a half (2.5) % between ranges.

7.7. The Association and the District will meet annually in April to review pay data compared to Areas 1, 2, 5 & 7 of the California Hospital Association salary survey data for pay ranges. Jobs that require adjustments in order for District to provide competitive wage for recruitment and retention will be identified. If a particular job market appears to move 2% (4.5%,7%,9.5%), that job will move to next range(s). This review will be completed for any range changes in order to be effective the first pay period of July of each contract year.

7.8. Job titles which are in dispute as to whether they are included or excluded from the bargaining unit shall be processed as set forth in the Employer-Employee Relations Resolution.

7.9. Certification recognition: Full Time and Regular Part Time employees who obtain certification in a specialty area or a degree from an accredited college related to work while employed by the District will receive a one-time bonus of $500 as recognition of their continuing education effort. Certifications funded by the District except for use of Educational Reimbursement funds available under Article 18 of this agreement, are excluded from the bonus system.

7.10. A manager may set an employee's pay above the minimum of the range based on the following guidelines:

Years of Experience	Minimum Starting Pay Rate
0-2 years	0-5%
3-5 years	5-10%
5+ years	10-14%

7.11. In certain circumstances, including hard to fill positions or applicants with considerable experience, an employee may be hired over the midpoint in the salary range. Human Resources will review all salaries of other staff in the same title in the same department to determine if other salary adjustments are necessary.

7.12. Employees designated to work in one of the following roles will receive additional compensation as follows:

Charge Nurse/Team Leader:
Receives a 5% increase for designation during a scheduled shift. Only applicable when three or more nurses are working for designated shift. In additional to providing patient care, collaborates with all members of the interdisciplinary team to ensure patients' needs are met during a shift based on job description

Lead Roles:
Move up 2 ranges and receive a 5% increase
Responsibilities:
Day to day operations
In-service department employees
Update policies and procedures
Ordering

Coordinator Roles:
Move up 4 ranges and receive a 10% increase
Responsibilities in addition to Lead role:
Provide leadership to department
Participate in long range planning
Facilitate problem solving
Represent area in meetings

7.13. Per Diem rates are set at current base pay plus ten percent (10%). During the first year of the contract Per diem employee's hired prior to January 1, 2014, will be paid base pay plus 10% or will remain at July 1, 2013 per diem rate whichever is greater (see appendix B). Once moving off of grandfathered scale employees will remain at 10% above base pay. As ranges change grandfathered employees pay will be reviewed and moved to base pay plus 10% as appropriate.

ARTICLE 8. Minimum Shift Pay

8.1. Employees may report to work to find that their services are not required

8.2. An employee who reports for his/her regularly scheduled work shift, but whose services are not required, will receive a minimum of two (2) hours pay at their base hourly rate of pay for reporting to work.

8.3. An employee who is notified not to report to work a minimum of two (2) hours prior to their scheduled shift, but who still reports to work will not be eligible for the minimum pay guarantee noted above.

8.4. An employee who is unavailable for such notification prior to the beginning of their shift will not be eligible for minimum shift pay.

8.5. An employee who is canceled less than the minimum of two hours prior to the start of a shift will be given the option to accept the full cancel day without pay, or work for two (2) hours.

8.6. Employees who come in on a scheduled day off to participate in ambulance transfers will receive minimum shift pay of four (4) hours at straight time.

8.7. Employees scheduled to participate in Radiology Diagnostic procedures will receive minimum shift pay of two (2) hours at straight time.

8.8. Employees scheduled to attend department meetings, in-services or committee meetings will be paid a minimum of two hours at their base hourly rate.

ARTICLE 9. Standby

9.1. Standby is defined as duty which requires that an employee be designated by the appointed authority to be ready to respond within 1/2 hour, road and traffic conditions permitting; be reachable by telephone or page system; and refrain from activities which might impair his/her ability to perform assigned duties. An employee who is assigned by the department to be on standby shall be eligible for standby pay.

9.2. Employees on standby or cancelled standby, with the exceptions of those job titles identified below shall receive one-third (1/3) of his/her base hourly rate of pay for each hour or fraction of an hour on standby except for Holiday standby.

9.3. Standby or cancelled standby on designated holiday shifts shall be paid at the rate of one-half (1/2) of the employee's base hourly rate. If a change in the workload has

occurred and at the manager's discretion additional staffing is required, the employee on standby should be the first person called back to work.

9.4. Orthopedic and Surgical Physician Assistants/Nurse Practitioners, Pharmacists and Home Health / Hospice nurses will receive $100 per standby shift. Standby shifts on recognized holidays will be paid at $150 per shift.

Effective July 1, 2017:

Pharmacists will receive $20 per hour for each hour of standby. When scheduled for standby on a recognized holiday Pharmacists will receive $30 for each hour of standby.

Home Health/Hospice nurses will receive $10 per hour for each hour of standby. When scheduled for standby on a recognized holiday Home Health/Hospice nurses will receive $15 for each hour of standby.

9.5. Standby will usually occur in the following sequence:

1. Any employee who volunteers for standby, Full Time and Regular Part Time employees subject to manager's approval
2. Temporary or Seasonal
Casual Part Time
3. Per Diem
4. Short Hour
5. Regular Part Time, Full Time employees and Contract Agency on a rotational basis as appropriate.

9.6. Notification of change to standby will follow the same two-hour requirements as cancellations.

9.7. Hours worked after work status is changed will be paid at the appropriate callback rate.

9.8. Availability will begin at the start of the shift within expected callback response times.

9.9. Perioperative Services and PAAS employees will be paid to work on-call only positions on a seasonal basis. The on call only positions shall be assigned to any volunteers and/or equally rotated among surgery full time and regular part time staff.

ARTICLE 10. Cancel Standby

10.1. Cancelled Standby time shall be defined as hours assigned by the department instead of the regularly scheduled hours due to low census or other such reasons.

10.2. It is defined as duty which requires that an employee be designated by the appointed authority to be ready to respond within ½ hours, road and traffic conditions permitting; be reachable by telephone, cell phone or pager; and refrain from activities which might impair his/her ability to perform assigned duties. An employee who is assigned by the department to be on cancelled stand by shall be eligible for standby pay

10.3. Management staff shall notify an employee if they are to be placed on cancel standby two (2) hours prior to the beginning of their shift.

ARTICLE 11. Callback

11.1. Callback is defined as pay earned by an employee who is called in to work from standby status.

11.2. An employee who is called into work shall receive a minimum guarantee of two (2) hours at time-and-one-half for an initial callback.

11.3. An employee who is called into work on a designated holiday shift shall receive a minimum guarantee of two (2) hours pay at double time for an initial callback.

11.4. Subsequent callbacks within the two hour callback period will not receive additional compensation.

11.5. Callbacks occurring after the two hour period has passed will be considered a separate callback and will be compensation as a separate callback beginning a new two hour callback period.

11.6. Travel time to and from the workplace shall not be considered as hours worked for purposes of computing callback pay. When an employee is called into work, standby pay will be reduced by the number of callback hours paid.

ARTICLE 12. Cancellation

12.1. Cancellation is defined as an employee's temporary reduction of scheduled hours as a result of reduced staffing requirements on a daily basis subject to managers approval.

12.2. Cancellations will occur in the following sequence:

1. Employee working an overtime shift
2. Volunteers working an additional shift
3. Volunteers willing to use PL on a rotational basis (Volunteers using PL for a cancelled shift will not have that shift considered a cancelled shift)
4. Volunteers on a rotational basis
5. Employee working an additional shift
6. Temporary/Seasonal/Casual
7. Per Diem
8. Short Hour
9. Regular part time, full time and contracted agency on a rotational basis

12.3. An employee, who would otherwise be cancelled, may be floated at the department head/ supervisor's discretion.

12.4. Management shall notify an employee if he/she is to be cancelled two (2) hours prior to the beginning of his/her shifts. If an employee is cancelled within 2 hours of the beginning of the shift, he/she will be given the option to accept the full cancelled day without pay, or to work for 2 hours.

12.5. A cancelled employee may elect to be paid for Personal Leave up to the number of hours cancelled with a minimum Personal Leave payment of one hour.

12.6. An employee who has been cancelled need not be available by phone after the notification of cancellation.

ARTICLE 13. Pay for Working Scheduled Day Off

13.1. After a department schedule is posted, a manager/supervisor may ask a Full Time employee to work on a scheduled day off. Full-Time employees scheduled to work an additional shift on a scheduled day off will be paid at time and one half of the employee's base hourly rate. If the employee voluntarily elects to take paid time off during the same work week, requests another day off in exchange, calls in sick or volunteers for first cancel, the shift will be paid at straight time.

ARTICLE 14. Personal Paid Leave

14.1. Full Time, Regular Part Time employees are eligible to accrue Personal Paid Leave hours.

14.2. Accrual of Personal Paid Leave begins immediately upon employment and is based upon hours paid, exclusive of overtime, standby and callback hours, with the exception that scheduled working hours that are changed to cancel standby hours will accrue Personal Paid Leave.

14.3. Personal Paid Leave is paid time off to be used for an employee's needs including, holidays, vacations and short-term illnesses. An employee must use Personal Paid Leave hours when he or she works less than their work status unless the time off is the result of cancellations.

14.4. Personal Paid Leave Accrual Schedule:

14.5. Full time employees will accrue Personal Leave based on status. That is full time employees working 12 hour shifts will accrue PL based on 72 hours a pay period, full time employees working 8 or 10 hour shifts will accrue PL based on 80 hours a pay period.

14.6. Full time Laboratory employees working nights will accrue PL based on 70 hours a pay period.

14.7. Employees Hired Prior to 10/31/86 accrue personal paid leave at the rate of 39 days per year or the rate of 0.15 hours per hour.

14.8. Employees Hired After 11/01/86:

Yrs. of Service	0-4	5-8	9-11	12-14	15	16+
Max. Days/Year	24	29	32	33	34	36

Hourly Accrual	.092	.112	.123	.127	.131	.139

14.9. No Full Time employee shall be allowed to accrue in excess of 240 hours of Personal Paid Leave. No Regular Part-Time employee shall be allowed to accrue in excess of 190 hours.

14.10. Employees unable to work a scheduled shift due to unforeseen circumstances are required to notify their department manager at least two hours prior to the beginning of the shift if practical.

14.11. Additional Personal Paid Leave hours will be granted to night shift employees (shifts beginning on or after 7:00 p.m. and before 5:00 a.m.) at the rate of eight hours of additional Personal Leave for every one hundred and seventy three (173) hours of straight time paid. This bonus will be granted quarterly and the Personal Leave hours will be credited to the employee's account on the first of the month following the end of a quarter. The maximum number of additional Personal Leave hours accrued will be Ninety six (96) hours annually.

ARTICLE 15. Long Term Sick Leave

15.1. Full-Time and Regular Part-Time employees accrue Long Term Sick Leave in addition to Personal Leave. Short Hour, Temporary and Per Diem employees are not eligible for Long Term Sick Leave.

15.2. Full-Time and Regular Part-Time employees will accrue Long Term Sick Leave at a rate of .027hours for each hour paid, exclusive of overtime, standby and callback hours, with the exception that scheduled working hours that are changed to cancel standby hours will accrue Long Term Sick.

15.3. Following five consecutive years of employment and upon termination, Long Term Sick will be paid back to the employee at 50% of hours accrued, not to exceed $7,500.00 for employees who have twenty years of service. After twenty consecutive years of employment and upon termination, Long Term Sick will be paid back to the employee at 75%of hours accrued, not to exceed $12,500.00. After twenty-five consecutive years of employment and upon termination, Long Term Sick will be paid back to the employee at 75% of hours accrued, not to exceed $15,000.00. After thirty consecutive years of employment and upon termination, Long Term Sick will be paid back to the employee at 75% of hours accrued, not to exceed $17,500.00.

15.4. On calendar days one through four of any illness, an employee will utilize his/her Personal Leave account. Long Term Sick usage begins:

On the fifth calendar day of an illness,
Immediately upon hospitalization if sooner, or
If the employee is eligible for and receives Worker's Compensation.

15.5. Paid time off for illness will be taken from the Long Term Sick Leave account if the employee qualifies for State Disability insurance or Workers' Compensation payments. If an employee does not qualify for either program; paid time off for illness will be taken from the employee's Personal Leave Account. When the employee qualifies for State Disability insurance or Workers' Compensation payments, the paid time off for illness will be integrated to provide for 100% of base pay up to the maximum amount available under each program.

15.6. A department manager may request that an employee provide a physician's statement verifying illness or to verify ability to return to work.

15.7. Employees returning directly from sick leave shall be allowed to return to the position which they formerly occupied. If such position is subject to reduction in force at the time an employee seeks to return directly from sick leave status, the returning employee may exercise his/her seniority with respect to such position. Employees who are unable to return to work when their sick leave reserve and personal leave hours are exhausted may request a leave of absence.

15.8. Employees on sick leave shall not have their anniversary date affected.

ARTICLE 16. Paid Sick Leave

16.1. Paid Sick Leave is a paid benefit to allow California based employees in non-benefitted job classifications (per diem, short hour, casual hour, and temporary, seasonal) to accrue paid time off to be used for the employee's illness or to care for a family member. Eligible mandatory leave programs will run concurrently such as Paid Sick Leave, Kin Care, FMLA/CFRA, among others. Paid Sick leave should not to be confused with Personal Leave (PL) or Long Term Sick Leave (LTS).

16.2. This benefit only pertains to employees who are not eligible for PL/LTS accrual. Full time and Regular Part Time employees are benefited employees and are covered under their PL benefit.

16.3. Paid Sick Leave is used for:

16.4. Employee eligibility to use Paid Sick Leave begins on their 90th day of employment.

16.5. Employees accrue one (1) hour of paid sick leave for every 30 hours worked, with annual maximum accruals as follows:

Employees working 8 hour shifts accrue a maximum of 24 hours of sick leave.
Employees working 10 hour shifts accrue a maximum of 30 hours of sick leave
Employees working 12 hour shifts accrue a maximum of 36 hours of sick leave
Employees working 6 hour days are allowed more than 3 days sick until they have used the maximum accrual of 24 hours.
Benefits may roll over each year but will not exceed a maximum of 48 hours.
Accrual rate is .0334 per hour worked.

16.6. Minimum one (1) hour of Sick Leave may be used for partial sick days.

16.7. If the leave is foreseeable, employees are required to give reasonable advance notice, if unforeseeable, employee must give notice as soon as possible.

ARTICLE 17. Health Dental Vision and Life Insurance

17.1. All Full Time and Regular Part-Time employees are eligible to participate in the District's group health insurance program.

17.2. Coverage for the new employee and eligible dependents shall become available the first of the month following completion of the initial sixty (60) calendar day employment period.

17.3. Health Plan Design and Premiums: The plan design is described in Appendix C. This plan will remain in effect from January 1, 2016 subject to provisions in 16.4.

17.4. Premiums for participation in health, dental and vision plans are outlined in Appendix D. Subsequently, the District will look at the annual actuarial study projecting claims costs. If the plan costs are projected to exceed 10%, the plan design and premium costs may be changed through the meet and confer process. If the costs are projected to be 10% or less, then premiums will be set based on the projected annual increase. The percentage increase will be split equally between the District and the employees; the employee premium cannot increase more than 10% per year. (E.G. if the costs are projected to increase 8%, the employee premium will increase by 4%. The District is accepting the majority of the increase as 4% of the District's share of costs is considerably higher than the premium share.)

17.5. Premiums will be reduced for employees who elect to participate in an annual health screening. Reduced premiums are outlined in Appendix D

17.6. An employee who is on Leave of Absence for a personal emergency or bereavement not covered by Family Care Leave or Layoff status which exceeds thirty (30) calendar days must assume the entire premium cost during the second month and all succeeding months of the Leave of Absence or Layoff. All others on a Leave of Absence will be eligible for health insurance benefits under COBRA beginning on the first day of the leave.

17.7. An employee who does not elect COBRA benefits and allows insurance coverage to expire shall be considered a new employee with respect to health insurance waiting restrictions, as described above, upon return from his/her leave of absence or layoff.

17.8. The District agrees to maintain health insurance benefits for full-time and regular part – time employees for the life of this Memorandum of Understanding (excluding health plan as addressed above).

17.9. It is agreed that the District may change insurance carriers so long as the level of benefits is not decreased.

17.10. Employees not covered by the District’s insurance may seek assistance from financial counselors in the District’s finance office for services from the District.

17.11. The District will provide a dental program for all employees eligible to participate in the group health insurance program.

17.12. The District will provide a vision plan for all employees eligible to participate in the group health insurance program.

17.13. The District will provide a $25,000 life insurance policy for all employees eligible to participate in the group health insurance program.

ARTICLE 18. Educational Reimbursement

18.1. Full Time, Regular Part Time and Per Diem and Short Hour employees who have completed six months of continuous service will be eligible to receive reimbursement for college accredited courses, seminars, conferences, workshops and other educational meetings that are related to current job competencies and/or support professional practice and excellence.

18.1.1. Paid Educational Leave Allowance Per Year

Full Time employee:	24 hours per fiscal year
Regular Part Time:	16 hours per fiscal year
Per Diem and Short Hour staff who work greater than 1000 hours in the prior fiscal calendar year:	8 hours per fiscal year

18.1.2. Expense Reimbursement

Full Time employee:	$450.00 per fiscal year
Regular Part Time:	$325.00 per fiscal year
Per Diem and Short Hour staff who work greater than 1000 hours in the prior fiscal calendar year:	$250.00 per fiscal year

18.2. Surgical Nurse Practitioners/Physician Assistants receive:

18.2.1. Paid Educational Leave Allowance Per Year

Full Time employee:	24 hours per fiscal year
Regular Part Time:	16 hours per fiscal year
Per Diem and Short Hour staff who work greater than 1000 hours in the prior fiscal calendar year:	8 hours per fiscal year

18.2.2. Expense Reimbursement

Full Time employee:	$1500.00 per fiscal year
Regular Part Time:	$1125.00 per fiscal year
Per Diem and Short Hour staff who work greater than 1000 hours in the prior fiscal calendar year:	$830.00 per fiscal year

18.3. Payment for college courses will be received upon successful completion of the course and will be based on the employee's status at the time of completion.

18.4. Prior approval by the employee's department head and Human Resources is required to be eligible for reimbursement. Reimbursement amount may be applied towards the cost of registration, books, related material and related expenses in accordance with IRS guidelines.

18.5. The employee that is required to maintain licensure shall assume responsibility for the cost of re-licensure.

18.6. Fiscal year is July 1 through June 30.

18.7. If pay is to be received, an employee attending an approved educational meeting should indicate "MOU Educational Leave" on his/her variance log.

18.8. Reimbursement for approval of educational paid days and expense reimbursement are to be submitted at least two weeks in advance on the approved form. Registration only will be paid in advance. Requests for advance payment are to be submitted at least one month in advance on the approved form to the employee's department manager.

18.9. Benefits will not be accrued on "MOU Educational Leave" pay. Overtime will not be paid.

18.10. Unused hours and expense reimbursement will be carried over at the end of the fiscal year. At no time will employees be allowed to accrue more than two times the annual allotted hours or expenses.

18.11. To receive the reimbursement check, proof of attendance must be submitted to the employee's department manager for approval. All expenses must be documented on an Expense Report Form and receipts provided.

ARTICLE 19. Premium Holiday Pay

19.1. Employees shall be paid time-and-one-half of their base hourly rate for all hours worked on the following days:

New Year's Day
President's Day
Memorial Day
July 4th
Labor Day

Thanksgiving Day
Christmas Eve Day
Christmas Day
New Year's Eve Day

19.2. Premium pay is received for hours worked during the actual 24 hours of the holiday.

ARTICLE 20. Hours of Work

20.1. The District's standard work period shall be eighty (80) hours in any two-week period.

20.2. Employees assigned to work 8 hour shifts, will receive overtime pay at a rate of one and one-half (1 1/2) times the employee's pay for all time worked in excess of eight (8) hours in any one (1) day or eighty (80) hours in any two (2) week pay period.

20.3. Employees assigned to work 10 hour shifts will be paid overtime for hours worked in excess of ten (10) hours per work day or forty (40) hours in any workweek.

20.4. Employees assigned to work twelve (12) hour shifts will be paid overtime at a rate of one-and-one-half (1 1/2) times the employee's pay for hours worked in excess of twelve (12) in one day or forty (40) hours in a seven day work week.

20.5. Employees working in excess of sixteen (16) consecutive hours, with a break of two hours or less, will be paid overtime at twice their hourly wage for all hours in excess of sixteen (16) hours worked.

20.6. The District may enter into voluntary agreements with individual employees who desire to be paid on a 40-hour workweek basis with overtime calculated only after 40 hours of work in a workweek. Such voluntary agreements shall be documented in each employee's personnel file.

20.7. The District will make reasonable efforts, when patient care permits, to rotate weekends equally among employees who work in departments that require weekend coverage. For those employees who work 8-hour shifts, a minimum of 4 weekend shifts per month will be expected. For those employees working 10 hour shifts, a minimum of 3 weekend shift per month will be expected. For those working 12-hour shifts, a minimum of 3 weekend shifts per month will be expected. If an employee elects to work every weekend, he/she may submit a written request to his/her manager or supervisor. If enough employees request to work weekends, other employees may have their weekend requirement reduced.

ARTICLE 21. Work Schedules

21.1. The District shall post work schedules at least fourteen (14) days in advance. At the time of the posting, it is the employee's responsibility to check the schedule.

21.2. Work schedules may be subject to change, with mutual agreement after posting, either to meet the needs of the employee or the District.

21.3. Shift trades will be permissible subject to manager's approval. Shift trades may not result in overtime.

21.4. Posted schedules will indicate the date posted and will be displayed in an area which is available to all employees at all times.

21.5. Employees unable to work a scheduled shift due to unforeseen circumstances are required to notify their department manager at least two hours prior to the beginning of the shift if practical.

ARTICLE 22. Leave of Absence

22.1. District employees may avail themselves of two types of leaves, regulatory leaves and an unpaid leave of absence.

22.2. Regulatory Leaves of Absence:

22.3. District employees may be eligible for a leave from work in a number of instances, including the following:

Family Medical Leave (FMLA)
California Family Leave (CFRA)
Pregnancy Disability Leave (PDL)
Military Leave (ML)
Occupational Disability (OD)

22.4. Administration of regulatory leaves is set forth in District policies based on state and federal statutes. Refer to district policies for eligibility, request processing, insurance premiums on leave, and other information.

22.5. Unpaid Leaves of Absence: When protection under other leaves is exhausted or an employee is ineligible for another type of leave, an employee may be eligible for an unpaid leave of absence. Unpaid leaves may be granted for a period of up to one (1) year at the discretion of the Department Director based on the business needs of the department.

22.6. Procedure for Unpaid Leave of Absence:

Eligibility: An employee must have completed one year of continuous employment to be eligible for an unpaid leave.

Requests: A request for a leave must be in writing to the department manager outlining the reason for the leave and length of time requested. A leave may be granted at the director's discretion base on the business needs of the department.

Health Insurance Premiums: The District will cover the cost of health insurance for the first thirty days of an unpaid leave for employee's who are not eligible for FMLA or CFRA leave. The employee is responsible to pay the premium cost for individual and dependent coverage during the first 30 days. Employees will be eligible to exercise their rights to continued insurance coverage for the second and all succeeding months of the leave under COBRA.

An employee who has exhausted all benefits including FMLA, CFRA, Long Term Sick Leave and Personal Leave will be eligible for COBRA benefits beginning on the first day of unpaid leave. The District will not cover COBRA costs for any portion of the unpaid leave.

Benefit Accrual: An employee granted an unpaid leave of absence shall not be eligible to accrue any benefits during the period of the leave, but shall have all benefits accrued prior to the leave reinstated upon his/her return to work.

Return from LOA: Employees who are not eligible for FMLA or CFRA returning from an unpaid leave of absence of thirty (30) calendar days or less will be reinstated to the same position in which they were employed before taking the leave. Such employees returning from a leave in excess of thirty (30) calendar days will be considered for the first available position for which they are qualified. Employees returning from a leave taken after FMLA or CFRA benefits have been exhausted will be considered for the first available positions for which they are qualified.

22.7. Date of Hire will be adjusted for by the length of an unpaid leave of absence greater than 30 days.

ARTICLE 23. Retirement

23.1. The District shall provide for retirement savings plans for employees.

23.2. The District maintains The Tahoe Forest District Employee's Money Purchase Plan for its employees.

23.3. All employees may participate in the 457-non-qualified Deferred Compensation program.

23.4. The District will match employee contributions for Full Time and Regular Part Time employees to the Section 457 Deferred Compensation Plan up to a maximum of 3% of the employee's gross income with increases described in the Longevity Retention Bonus article.

ARTICLE 24. Longevity Retention Bonus

24.1. Employees hired prior to July 1, 2013 who have completed 10 years or more of employment:

24.1.1. Full and Regular Part Time employees will receive lump sum bonus payments in five-year increments according to the following schedule.

24.1.2. Longevity retention match and bonus benefit schedule.

Longevity Level	Lump Sum Bonus	Deferred Compensation
Level 1; at 10 years	None	Deferred Compensation match to 6 %

Level 2; at 15 years	2% lump sum bonus paid based on earnings of prior five calendar years (PRIOR BONUS PAYMENTS EXCLUDED)	Deferred Compensation match to 7%
Level 3; at 20 years	5% lump sum bonus paid based on earnings of prior five calendar years (PRIOR BONUS PAYMENTS EXCLUDED)	Deferred Compensation match continues at 7%
Level 4; at 25 years	7% lump sum bonus paid based on earnings of prior five calendar years (PRIOR BONUS PAYMENTS EXCLUDED)	Deferred Compensation match continues at 7%

Level 4 is repeated in five-year increments

24.2. Employees hired or reaching 10 years of service after July 1, 2013

24.2.1. Full and Part time employees will receive lump sum bonus payments in five-year increments according to the following schedule.

Level 1: At 10 years: Deferred Compensation match to 6%

Level 2: At 15 years: 2% lump sum bonus paid based on earnings of prior five calendar years
(PRIOR BONUS PAYMENTS EXCLUDED)
Deferred Compensation match to 7%

Level 2 is repeated in five-year increments

24.3. Each level is achieved during the anniversary year of 15, 20, and every 5 years thereafter. The payout will be made on May 30 for those with a date of hire between January and June and on November 30 for those with a date of hire between July and December. Payout will be calculated on prior five calendar years wages as defined for lump sum payments.

24.4. For employees currently on the longevity program whose previous bonus payout does not coincide with the anniversary date for date of hire, a longevity retention bonus date will be identified based on last payout date and the future payouts will be in five year increments as set forth above.

ARTICLE 25. Bereavement Pay

25.1. Full Time and Regular Part Time employees shall be granted bereavement leave of up to three (3) workdays, with pay, in the event of the death of a member of their immediate family. If the employee is required to travel over five hundred (500) miles (one-way) to the memorial services, he/she may be granted two (2) additional days with pay. Payment for such days shall be deducted from accrued Long Term Sick Leave hours.

25.2. Immediate family is defined as: spouse, parent, grandparent, child, stepchild, sister, brother, mother-in-law, father-in-law, brother-in-law, sister-in-law, grandchild, or member of the household or a person standing in loco parentis.

ARTICLE 26. Job Vacancies

26.1. Job postings: When new positions are created, temporary positions are classified as regular positions, or vacancies occur due to employees leaving a position, the District shall post the vacant position on the online posting site. Such notice shall set forth the number of vacancies, the job classification, a brief job summary, licensure and/or certification requirements, rate of pay, and the date posted. Employees apply for positions using the online application. HR will route all internal candidates and all qualified external applicants to hiring managers.

26.2. Positions may be filled on a temporary basis during the posting period. Position openings will be posted outside of the department if no employee in the department is currently working in the job classification.

26.3. Internal posting (within the department). If the open position is for a job title that employees are currently working in the department, the position will first be posted in the department and online as a department only posting for a period of five days. Department employees will be considered in the following manner for the position:

Full time and regular part time based on the most recent effective date for a transfer to a benefited position within the department. If not filled at this level:

Short Hour, Casual and Per Diem employees will be considered based on qualifications, experience and date of hire to the District.

26.4. External postings: Candidates will be considered based on qualifications and experience. If candidates are equal in qualifications and experience, preference will be given based on first date of hire to the District.

26.5. If applicants meet job description qualifications, hiring manager has the right to review prior two years performance evaluations to identify any ratings under 3.0 and any disciplinary actions within the last 18 months. Hiring manager may take into consideration after discussion with applicant. If two applicants are equally qualified. Preference will be given based on first date of hire within the District.

ARTICLE 27. Layoff and Recall

27.1. Layoffs and recall shall be within department by classification and employee status.

27.2. The sequence of employees' status to be laid off shall be as follows:

Any employee who volunteers;
Temporary and Seasonal employees
Per diem employees
Short Hour and casual part-time employees
Regular part-time and full time employees on an equal basis

Within each status, layoffs will be applied in the following manner:

Date of hire into department,
Date of hire into current job classification,
Last date of hire with the District.

27.3. Date of hire is adjusted for unpaid leaves in excess of 30 days.

27.4. Employees remaining on the job shall be able to perform the work without the need of retraining and must be able to work the remaining shifts.

27.5. Recall from layoff shall be in the inverse order of layoff. Any employee who has volunteered for layoff shall be entitled to recall based upon status.

27.6. In the event that an employee is on layoff status for over twelve (12) months, he/she shall be terminated.

27.7. A full time or regular part time employee on layoff status may elect to leave accrued Long Term Sick hours in their benefit bank for the period of time they remain on the recall list. Employees may request payment of eligible LTS hours at any time while on layoff/recall status.

27.8. All employees on layoff shall notify the Human Resources Department of their status on a weekly basis. In the event that an employee is unable to return to work within seven calendar days from receipt of notice of recall, he/she may be terminated, but in no event (barring emergencies) shall an employee be given more that fifteen (15) calendar days to return to work from the date the notice to return was mailed by the District. Said notice shall be mailed by way of certified mail.

27.9. The District will notify the Association at least 30 days prior or as soon as a plan for any layoffs or department reorganizations has been approved that will result in a change to an employee's work status.

27.10. The parties will meet to discuss the reason for the layoffs, the planned schedule and any alternatives such as Voluntary Exit Incentive offerings.

27.11. When layoffs are anticipated, no posted positions and/or anticipated openings in the affected job classifications will be hired into until those employees have an opportunity to

transfer to such position for which they are qualified (requiring only the customary training and orientation provided to newly hired employees).

27.12. HR will review open jobs and expected openings and notify managers/directors not to fill those positions until the EAP and HR can meet and confer possible relocation to said positions. Posted positions will be removed from the job posting board until all staff movements have been resolved.

27.13. Any employee who transfers to a new position or is recalled to a vacant position will be given 90 days to demonstrate his/her ability to perform the work. Evaluation of performance during the 90 days will be based on skills, ability and behaviors. If the employee transfers to an open position and does not satisfactorily perform the duties, the employee will be placed on layoff and will be eligible for any compensation he/she would otherwise have received.

27.14. If in those 90 days the employee does not perform satisfactorily he/she will be returned to the recall list.

27.15. Bumping Rights: In the event of layoffs, an employee who has been promoted or transferred into a different classification and/or department shall retain the right to return to the classification and/or department from which he/she was promoted or transferred. Employees will retain months of service credit in the prior job classification. If an employee exercises bumping rights, said employee must be qualified and able to perform the job the employee formerly held with a reasonable reorientation and must be able to work existing shifts. The employee must be able to perform the basic competencies within the job description without retraining.

ARTICLE 28. Shift Differential

28.1. Employees will receive shift differential for working certain hours.

28.2. Employees whose scheduled shift end on or after 7pm will be paid a shift differential of $2.50 per hour for those hours worked after 3:00pm.

28.3. Employees whose schedule shift ends on or after 3:00 am will be paid a shift differential of $3.75 per hour for those hours worked after 12:00 midnight.

28.4. Employees, whose schedule shift commences after 12:00 midnight, and at or before 5:30 am, shall receive a shift differential of $3.75 per hour, in addition to their base hourly rate until 8 am.

28.5. Employees working the weekend shift will receive $1.50 per hour during the 48 hour period between 7:00 pm Friday and 6:59 pm Sunday.

28.6. The shift differential shall only apply to hours worked.

ARTICLE 29. Grievance Procedure

29.1. Grievance, Adjustment and Binding Arbitration/Hearing

29.2. Definition/Protocol: A grievance shall be defined as a dispute concerning the interpretation or application of any express provision of this Agreement. An employee may be represented by the Association at any Step in the procedure. A grievance can also apply to any issue or dispute concerning the interpretations or application of policies and procedures within the scope of bargaining. The District shall notify the Association of any disciplinary suspension or discharge imposed on any bargaining unit employee. Suspension based on lapse of required license, certification or legally required health screen will not be deemed a "disciplinary" suspension for purpose of Association notification. A grievance may be filed by the Association or by an employee.

29.3. Grievance Procedure: The grievance procedure is a process that allows employees and/or Association representatives and a department head or supervisor to address disputes in a formal manner if they are unable to resolve the issue in an informal manner. The steps of the grievance procedure are as follows:

Step One – Informal Discussion: Employees/Association representatives are asked to discuss their grievance with the department head or supervisor in an attempt to resolve the dispute in an informal manner.

Step Two – Written Grievance/Formal Discussion: If the employee or Association representative feels that the dispute was not settled in Step One, they may submit the grievance in writing to the department head or supervisor. The department head or supervisor has three days to discuss the matter with the grievant.

Step Three – Mediated Discussion: If a resolution is not reached at Step 2, the grievance may be presented to the Human Resources Director within ten days of the formal discussion at Step 2. The Human Resources Director or designee may direct the department head or supervisor to meet with the employee and the Human Resources director or designee to discuss the matter. The Human Resources director or designee will arrange the meeting no later than 10 days from the date of presentation to the Human Resources Director. The Human Resources Director or designee shall forward a written response to the grievance to the Association President within five days after the Step Three meeting.

Step Four – Board of Adjustment: If the grievance is not settled in Step 3, the grievance may be submitted to an Adjustment Board by delivering written notice to the Human Resources Director within ten days of delivery of the Step Three written response. The Adjustment Board consists of two District representatives and a representative from each of the currently certified employee associations for a total of four members. The District shall be solely responsible for choosing its representatives and the Association shall be solely responsible for choosing its representatives. The Adjustment Board members are responsible to hear both sides in the dispute and render a decision if the provisions of the Memorandum of Understanding have been met. The representatives do not represent one side of the dispute or another. They are intended to be impartial and hear both sides in the dispute.

Step Five – Arbitration: If the grievance is not resolved in Step 4, either the District or the Association may submit a request to initiate binding arbitration. Individual employees may not submit a request for arbitration or otherwise move a grievance past Step Four. An Association request to submit the matter to arbitration must be filed with

the Human Resources Director within 10 days of completion of Step 4. A District request to submit the matter to arbitration must be submitted to the Association President within 10 days of completion of Step 4. Only the Association or the District (not individual employees) may move a matter to arbitration.

29.4. If the grievance involves a District procedure or general interpretation of the contract and is submitted by the Association, the grievance automatically advances to Step 3. If the grievance involves a suspension or termination, the grievance automatically advances to Step 4. Grievances alleging unlawful harassment, discrimination or retaliation by an individual supervisor or Department Head may be submitted directly to the Director of Human Resources and advanced to Step 3.

29.5. In order to be timely, a grievance must be submitted at the Step 2 level in writing to the other party within thirty days of the event giving rise to the grievance, or within thirty days of the time when the grievant knew or, with reasonable inquiry, should have known of the event. Grievances related to suspension or termination must be filed within ten days from the date of notification to the employee or the Association of the action.

29.6. Arbitration Procedure (Step 5):

29.6.1. The Human Resources Director or designee and an Association representative will promptly meet to attempt to mutually select an Arbitrator. If they cannot agree, either the District or the Association may ask the California Conciliation Service or another entity agreed between the parties to submit seven names of arbitrators. The Association and the Human Resources Director or designee shall meet within five working days after receiving the list of arbitrators to alternately strike names until only one person remains. The first strike shall be determined by coin toss.

29.6.2. The arbitrator should convene an arbitration hearing as soon as practicable. Each party to the dispute shall have the opportunity to present evidence, to cross-examine witnesses, and to submit written briefing following the hearing. The arbitrator shall render a written decision and findings of fact as soon as conveniently possible.

29.6.3. The expenses of the arbitration, including the arbitrator's fees, the cost of a reporter and arbitrator’s transcript copy, and other expenses incidental to the arbitration shall be shared equally by the Association and the District; except, however, each party shall bear the total cost of preparation and presentation of its own case and witnesses including, but not limited to, any transcripts requested by a party.

29.6.4. The arbitrator shall be empowered to determine all factual controversies and all questions of interpretation and application of any clause of this Agreement that may be relevant to the arbitration. The arbitrator shall not have authority to add to, subtract from or change any provision of this agreement or District policy in any way. Jurisdiction shall extend to claims of violation of specific written provisions of the Agreement or interpretation or application of hospital policies within the scope of the grievance and involve only the interpretation and application of such provisions.

29.6.5. The arbitrator may not award back wages to the grievant beyond 15 days prior to the date of filing of the grievance, unless the grievant did not know, or could not have reasonably known of the event, that caused the grievance.

29.6.6. The arbitrator may award reinstatement only or reinstatement with full or partial back pay in all disciplinary disputes (demotion, suspension or discharge matters).

29.6.7. The arbitrator's decision shall be final and binding upon both parties, except upon formal hearing review by the Board of Directors.

29.6.8. The arbitrator's findings or conclusions regarding either party's compliance with federal, state or local law shall be limited solely to the arbitration and shall not stop any party from litigating or establishing its compliance with such laws in any other forum.

29.6.9. The Board of Directors may review the decision of the arbitrator and hold a further formal hearing review upon motion to do so. A motion to hold a further formal hearing shall be made and decided within 14 days of the District's receipt of the arbitrator's decision; if there is no successful motion to hold a further formal hearing, the arbitrator's decision shall become final and binding upon all parties.

29.6.10. If the Board of Directors decides to hold a further formal hearing, it shall do so with at least 14 days' notice to each party. The hearing review shall consist of a review of the written transcript and exhibits from the arbitration hearing and formal argument presented by the District's representative and the Association's representative. The Board of Directors may also consider evidence or testimony that was excluded by the arbitrator; each party shall be allowed to make, and to respond to, requests for introduction of such evidence or testimony.

29.6.11. The Board of Directors' decision shall be final and binding upon both parties.

29.6.12. The Board of Directors' findings or conclusions regarding either party's compliance with federal, state or local law shall be limited solely to the formal hearing and shall not estop any party from litigating or establishing its compliance with such laws in any other forum.

29.7. Written Grievances: In order to be valid, a written grievance must state facts upon which the grievance is based, the provision(s) of this Agreement which have been violated or are in dispute, and the requested remedy.

29.8. District Grievances: District grievances shall be submitted at the Step 3 level in writing directly to the Association President. An Association Representative and the Human Resources Director or designee shall meet in an effort to resolve the grievance within ten days of the date of the written grievance. The Association shall forward a written response to the grievance to the Human Resources Director within five days of the first Step Three meeting. If the matter is not resolved, the matter may be submitted to Step 5 binding arbitration by written notice to the Association President within five days of delivery of the Step Three written response.

29.9. Grievances Concerning Strikes or Lockouts: If the District's or the Association's grievance involves alleged violation of the parties' No Strike/No Lockout agreement, the party claiming to be aggrieved may choose among the Grievance and Arbitration Procedure, Public Employment Relations Board (PERB) proceedings or judicial proceedings, as it deems appropriate and proper and consistent with any body's jurisdiction, and may proceed immediately to Step 5 if that option is chosen.

29.10. Time Limits: The term "days" as utilized in this article shall be defined as "calendar" days. Time limits may be waived only with the mutual written agreement of the parties. Unless waived or modified by express written agreement, the time limits contained herein shall be strictly construed. No grievance shall be arbitrable unless all time limits have been met. If a party fails to respond, or to respond in a timely fashion, the other party may move the grievance to the next Step. If a party has responded and the other party fails to give timely written notice of intention to move the grievance to the next Step, the grievance will be deemed to have been resolved on the basis of the party's last response. The failure to insist upon strict compliance with these time limits and requirements in one or more grievance(s) shall not affect the right to do so in any other grievance.

29.11. Forms and Documents: Necessary forms or documents to be utilized under this procedure shall be adopted by the parties.

ARTICLE 30. Discipline and Discharge

30.1. Employees may be disciplined or discharged, for just cause, for infractions not consistent with District policy and procedures and/or professional conduct according to the following process.

30.2. During their initial probationary period, employees may be disciplined or discharged at the District's discretion without recourse to the grievance procedure or just cause standard.

30.3. Supervisors may provide informal coaching that is not documented in an employee's personnel file. Informal coaching is a values-supportive discussion regarding behavioral choices and shall not be considered discipline.

30.4. Depending on the nature of the infraction, the District will discipline the employee in accordance with the following progressive steps:

30.5. All proposed disciplinary will be reviewed through the just culture algorithm before action is taken.

30.6. Major misconduct may be cause for immediate discharge when consistent with just cause.

30.7. The parties agree that any discipline or discharge following the initial probationary period shall be subject to the standards and review procedures expressly provided under this Agreement.

30.8. Investigative Interviews. Management may, as deemed necessary, meet with an employee prior to notification of intent to impose a disciplinary action in an effort to obtain information. An employee may, upon request, have an Association representative present during any investigative interview that may result in discipline or discharge of the employee. This provision is intended to secure Weingarten-type rights as applicable to employees represented under the Meyers-Milias-Brown Act.

30.9. Meeting to Notify of Intent to Impose Discipline (Prediscipline). The District shall hold a prediscipline meeting before imposing a written reminder, unpaid suspension, Decision Making Leave or termination on an employee who has completed the initial probationary period.

30.10. The District shall provide written notice of the alleged misconduct, copies of any written materials that will be placed in the employee's personnel file reflecting the planned discipline (for example, a copy of the planned written reminder), and an explanation of any documents or other evidence leading to the planned discipline, to the employee at least seventy-two (72) hours prior to the prediscipline meeting. The employee may be placed on paid leave from the time the District notifies the employee of the planned prediscipline meeting until the meeting is held, but paid leave shall not run for more than one calendar week.

30.11. The prediscipline hearing shall include a representative of management and a second management representative, who was not involved in the initial disciplinary decision, and who shall be one of the District employees trained in Just Culture management principles.

30.12. The employee may, orally or in writing, provide a response to the proposed discipline and tell his or her side of the story regarding conduct or events leading to the planned discipline. The employee may provide any information that may lead to the District reversing its planned discipline.

30.13. The employee may specifically address any issues that he or she believes may affect his or her reputation, standing, or community associations, or otherwise stigmatize the employee's public image or future employment prospects. The employee may also request that an Association representative be present at the meeting.

30.14. The second management representative shall also be permitted to approach District management or other District representatives with decision making authority regarding the planned discipline, including asking that they invoke their discretion to reconsider the truth of any facts leading to the planned discipline, or the discipline itself.

30.15. After the prediscipline meeting, the District shall provide a response to the employee and Association within five (5) days. That response may include removing the proposed discipline, reducing the proposed discipline, or upholding the proposed discipline. Should discipline be imposed, the employee has the right to challenge the discipline through the grievance procedure.

30.16. Copies of written warnings and documentation of disciplinary action will be placed in the employee's personnel file after being reviewed by the employee. Refusal to sign and/or rebuttal by the employee will also be made part of the file.

30.17. The District will notify the Association of any unpaid suspensions or terminations imposed under this Article.

ARTICLE 31. Job Descriptions

31.1. Job descriptions for classifications within the bargaining unit maintained by the District shall be made available to the E.A.P. upon request.

ARTICLE 32. Jury Duty

32.1. The District encourages its employees called for Jury Duty to serve. Only in cases of extreme scheduling problems will the District request that an employee be excused from Jury Duty.

32.2. If summoned, either as a witness in a work-related case or for Jury Duty, the employee shall present either the summons or subpoena to his/her Supervisor or Department Head the first work day following the receipt.

32.3. If an employee is summoned to Jury service, or is subpoenaed as a witness for a work related case, he/she will be paid for the hours scheduled to work that day or previously scheduled on personal leave. In the event the employee is released from the summons or subpoena with four or more hours remaining on his/her regularly scheduled shift, or prior to noon if the employee works an evening or night shift, he/she shall telephone his/her department head to inquire as to whether the department head wishes him/her to report to work.

32.4. When an employee receives a Jury Duty check for witness fees, he/she must endorse it over to the District and present it to the Payroll Department.

32.5. Employees will be compensated for Jury service only on days that they have been scheduled to work or scheduled for personal leave.

32.6. Employees on work related cases will be paid for time served and will only be reimbursed at their appropriate rate of pay.

32.7. At no time will Jury Duty pay result in overtime payment.

ARTICLE 33. Time Off Requests

33.1. Employees shall submit vacation requests in writing not later than February 1st of each year.

33.2. The form for such purposes will be provided by the District and will cover the period of April 1st to March 31st.

33.3. Employees are required to request time off in order of priority beginning with their first choice. Based on the number of requests for a specific time period, approval may be limited to two weeks.

33.4. Time off shall be approved or disapproved based upon date of hire or transfer into the department and the staffing needs of the District.

33.5. Department managers will review all requests and approve or disapprove an employee's first choice for time off as available. If an employee's first choice is unavailable, then the manager will select the next available choice from the employee's list. Department managers will continue to review and grant time off until all requests have been approved or disapproved.

33.6. The Department Manager shall respond not later than March 1st, approving or disapproving the request. On March 1 a list indicating approved time off requests shall be posted in the department.

33.7. Management does not have the right to cancel an approved time off, providing the employee has sufficient Personal Leave available.

33.8. Time off requests received after February 1 will be considered on a first received basis. Time off will be approved or disapproved following published department staffing guidelines. All requests will be approved or disapproved at least 6 weeks prior to the date of requested time off. Manager's failure to meet the deadline does not result in automatic approval of the time off request.

ARTICLE 34. Probationary Period

34.1. All employees serve an initial probationary period upon hire with the District. During the initial probationary period an employee may be discharged for any reason.

34.2. Full time, regular part time employees shall serve a probationary period of 90 calendar days.

34.3. Short hour, casual and per diem employees shall serve a probationary period of 6 months.

34.4. Probationary period related to promotion or transfer:

Employees who are promoted or transferred to a new position shall be given orientation as necessary and such employees shall serve a probationary period of ninety (90) calendar days. If the employee fails to perform satisfactorily during the probationary period, the employee shall be returned to his/her former position at the former rate of pay without loss of seniority.

34.5. Probationary period related to bumping rights:

If an employee exercises bumping rights as outlined in Article 27, said employee must be qualified and able to perform the job the employee formally held with a reasonable reorientation and must be able to work existing shifts. The employee must be able to perform the basic competencies within the job description without retraining. The employee will be subject to a ninety (90) day probationary period. If during this probationary period the employee fails to perform satisfactorily they will be returned to the recall list.

ARTICLE 35. E.A.P. Representatives

35.1. The District agrees to recognize E.A.P. Representatives, as duly elected by the members of the Employees Association of Professional's. The number of E.A.P. Representatives shall not exceed six.

35.2. E.A.P. Representatives may receive complaints and see that the terms and conditions of the Memorandum of Understanding are observed. The E.A.P. shall notify the District in writing of the names and assignments of all duly elected Representatives. Any change in Representatives shall be forwarded to the CHRO.

35.3. Representatives shall not engage in E.A.P. business on work time and shall not engage employees in any conversation regarding E.A.P. matters on that employee's work time except as set forth in this article. Work time does not include break periods, meal times or any other specified periods during the workday when employees are properly not engaged in performing their work tasks. Representatives may, on occasion, have a brief conversation with an employee about work-related problems. Such use of work time shall not be abused.

35.4. The E.A.P. will be allotted time during the General Orientation to give information on the Association to new employees, subject to the District's review of the material and scheduling preference.

35.5. The District will compensate Association Representatives for time spent in negotiations sessions, meet and confer sessions, representing employees in meetings with managers, attendance at Personnel/Retirement meetings, scheduled meeting with District Administration, and for participation in training programs when the District has requested Association attendance.

35.6. The EAP Board and district Administration shall meet at least quarterly.

35.7. The District will not unreasonably deny access to the District property to the EAP's attorney or consultants.

ARTICLE 36. No Discrimination

36.1. The Association and the District agree that neither the Association nor the District shall discriminate in any way on the basis of Association activity and both shall follow all federal and state regulations regarding discrimination in employment.

ARTICLE 37. Unemployment Insurance

37.1. The District shall provide unemployment insurance coverage for its employees,

ARTICLE 38. Full Understanding, Modifications, and Waiver

38.1. It is intended that this Memorandum of Understanding set forth the full and entire understanding of the parties regarding the matters set forth herein, and any other prior to existing understanding or agreements by the parties regarding the matters set forth herein, whether formal or informal, regarding any such matters, are hereby superseded or terminated in their entirety.

38.2. Except as specifically provided herein, it is agreed and understood that each party hereto voluntarily and unqualifiedly waives its right, and agrees that the other shall not be required to negotiate with respect to any subject or matter covered herein during the term of this Memorandum of Understanding; however, this shall not preclude the employees from filing grievances on the subject matter of this Agreement or interpretation thereof.

38.3. Any agreement, alteration, understanding, variation, waiver, or modification of any of the terms or provisions contained herein shall not be binding upon the parties hereto unless made and executed in writing by all parties hereto, and if required, approved and implemented by the District's Board of Directors and the E.A.P.

38.4. The waiver of any breach, term or condition of this Memorandum of Understanding by either party shall not constitute a precedent in the future enforcement of all its terms and provisions.

ARTICLE 39. Savings Clause

39.1. Both parties intend to honor the provisions of the Memorandum of Understanding as they have been defined and developed under the Meyers-Millias-Brown Act. If any provision of this Memorandum of Understanding is found to be unlawful as the result of a final decision by a state or federal court or agency having authority to render such decision, the remaining provision of this Memorandum of Understanding shall remain in full force and effect.

ARTICLE 40. No Strike-No Lockout

40.1. No Strike or Interference: The parties realize that District facilities are different in their operations from other industries because of the nature of services rendered to the community. For this reason, during the term of this Agreement, employees covered by this Agreement shall not engage in any strike, sympathy strike, slowdown, sit-down, work stoppage or boycott at any of the District's premises, or other interruption of work or interference with the District's operations. Neither the employees, the Association, nor any of its officers, agents or representatives shall authorize, assist, lend support to, or in any way participate in any such activities at any District facility.

40.2. No Lockout: The District shall not lockout employees represented by the Association and subject to this Agreement during the term of this Agreement.

ARTICLE 41. Safety

41.1. The District shall provide safe working conditions consistent with all State and Federal standards which are applicable to the District. If an employee receives a work assignment which he/she believes is not in accordance with this requirement or believes that the general working conditions are not in compliance with this requirement, he/she may report such problems to the Administrator. The District shall promptly investigate any such complaint and where the District determines that the complaint has merit, it shall remedy the problem.

ARTICLE 42. Term

42.1. This Memorandum of Understanding shall be effective as of July 1, 2016 and shall continue in effect through June 30, 2019. No changes in this MOU provision can be made without the consent of both parties in writing.

42.2. The District and EAP will meet and confer prior to July 1, 2017 to bargain in good faith an increase to night shift Personal Leave accrual.

Employee's Association of Professionals	Tahoe Forest Hospital District
By:_____	By:_____
Stacey Tedsen on behalf of the Employee's Association of professionals	Jayne O'Flanagan, CHRO, on behalf of Tahoe Forest Hospital District

Appendix A

EAP Job Titles

Cardio Sonographer
Case Manager
Clinical Laboratory Scientist
Clinical Nurse Leader
Clinical Program Analyst
Clinical Psychologist
DI Coordinator
DI Tech II
DI Tech III
Dietitian
Exercise Physiologist
Infection Control Practitioner
Internal Clinical Auditor
Lead Case Manager
Lead Nurse - Cardiac Rehab
LVN
MRI Coordinator

MRI Tech
Nurse Practitioner/Physicians’ Assistant Case Manager
Nuclear Medicine Tech
Nurse Navigator
Nurse Practitioner
Occupational Therapist
Orthopedic Physician's Assistant/Nurse Practitioner
Patient Advocate
Pharmacist, CI Program Analyst
Pharmacist
Physical Therapist
Physician's Assistant
Pre-Admit RN Surgery
Radiation Therapist
Respiratory Care Practitioner
Respiratory Care Support
Social Worker
Speech Therapist
Staff Nurse
Staff Nurse/Educator
Surgical Board Coordinator
Technical Coordinator DI
Ultrasound Tech
Ultrasound Tech II

Appendix B

2012-13 Per Diem Ranges

E.A.P. Job Classifications 2013 Per Diem Rates	PD I Hire	PD II 5+ YOS	PD III 10+ YOS	PD IV 25+ YOS
Cardiac Sonographer	$46.16	$48.30	$50.44	$54.51
Case Manager, Acute	$62.08	$64.96	$67.84	$73.31
CLS	$49.70	$52.01	$54.32	$58.70
Diagnostic Imaging Tech III	$49.70	$52.01	$54.32	$58.70
Dietician, Acute	$42.86	$44.86	$46.85	$50.62
Occupational Therapist	$49.70	$52.01	$54.32	$58.70
Pharmacist, Retail	$75.63	$79.15	$82.66	$89.33
Social Worker, Home Health	$42.86	$44.86	$46.85	$50.62
Staff Nurse	$57.65	$60.32	$63.00	$68.08
Ultrasound Technologist	$52.22	$54.65	$57.07	$61.68

Appendix C

Health Plan Design

Following is a brief summary of health coverage. Full details are available in the Summary Plan Description.

MEDICAL	TFHD*	In Network	Out of Network
Calendar Year Deductible			
Individual	$500	$500	$1,000
Individual + 1 Dependent	$1,000	$1,000	$2,000
Family	$1,500	$1,500	$3,000
Out Of Pocket Maximum			
(Coinsurance + Deductible)			
Individual	$3,000	$3,000	$6,000
Individual + 1 Dependent	$6,000	$6,000	$12,000
Family	$6,000	$6,000	$12,000
Lifetime Maximum	No Lifetime Maximum		
In-Patient Hospital Services	100%	80%	50%
In-Patient Hospital Services Additional Copay/ Admit	none	$750	$1,000
Out-Patient Surgery	100%	80%	50%
Out-Patient Surgery Additional Copay/ Surgery	none	$750	$1,000
Lab & X-Ray	100%	80%	50%
Emergency Room			
Facility	$150	80%	50%
ER Physicians	80%	80%	50%
Physician's Office Visit	N/A	$30 Copay	50%
Urgent Care		$30 Copay	50%
Pain Clinic	$30 Copay	$30 Copay	50%
Surgery (In Physician office)	N/A	$30 Copay	50%
Mental Health/Alcohol and Substance Abuse			
In Patient	N/A	$500 Copay	$1,000 Copay
Out Patient	N/A	80% $40 copay	50% $40 copay
Prescription Drug Benefit - 34 day supply			
Generic	$10	$20	$40
Brand	$25	$45	$60
Non-Formulary	$50 or 50%	$60	$100
TFHD Only 90 Day Supply	90 day supply for 2-copays at TFHD only		

**TFHD refers to services provided and billed by Tahoe Forest Hospital District (TFHD). This does not include physician or other charges not billed by TFHD.*

DENTAL	Coverage
Deductible	$35 Individual $70 Family
Maximum Benefit	$1,500 Per Calendar Year per covered Individual
Class A Services - Preventive	100% (deductible does not apply)
Class B Services - Basic	80% (after deductible)
Class C Services - Major	80% (after deductible)
VISION	**VSP Coverage**
Copayment:	$20
Benefits:	
Exam	Once every 12 months
Lenses	Once every 24 months
Frames	Once every 24 months

Appendix D

Health Insurance Premiums

Monthly Premiums	Base	Screened
Full time single	$98.77	$48.77
Full time plus spouse	$247.81	$197.81
Full time plus child(ren)	$222.11	$172.11
Full time plus family	$331.32	$281.32
Part time single	$147.54	$97.54
Part time plus spouse	$346.27	$296.27
Part time plus child(ren)	$312.00	$262.00
Part time plus family	$457.60	$407.60

Executive Summary
Annual Renewal of MOU
FRC of Truckee and North Tahoe FRC
FY 2017

Purpose: To renew the ongoing MOU between TFHD and the Family Resource Center of Truckee and the North Tahoe Family Resource Center. To address the Board Goal that there shall be no inequities in health status in the community on account of race or ethnicity and to improve the health of the Latino population in the community served by the District in the amount of $96,001.00.

Methods: The Wellness Neighborhood accomplishes the goals and objectives of our work through collaborative partnerships and community engagement. This will be the third renewal of this MOU with the following goals:

- To engage targeted community members who have chronic diseases in comprehensive workshops -Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP) to provide skills and knowledge to manage their disease and improve their health outcomes
- To provide education, continuous quality improvement, and enhanced communication for all CDSMP and DSMP leaders.
- To support community members in identifying a medical home, engaging in preventative health care and assisting them in accessing follow up specialty care including dental health services
- To provide counseling support to underinsured and uninsured community members who present with at risk behavior

Major Accomplishments:

- In FY16 TFHD provided to train an additional 8 Promotoras as CDSMP and DSMP Leaders allowing us to offer more classes District wide in FY 17.
    - FY 16 there were 74 Class Participants
    - Class participants demonstrated improved knowledge of their health condition, increased their confidence in their ability to make goals and implement behaviors to support their disease management.
    - Class participants demonstrated improved medication adherence and follow-up care.
- 464 Community members received assistance with Covered California applications, care navigation, referrals to medical processionals and facilitation with access to care.
- 16 clients received direct behavioral health services with a bi-lingual therapist

Additional Initiatives for FY 17 include:

- Implement monthly trainings and quarterly educational meetings for all Promotoras through Q-TAC Nevada to insure high quality community education.
- Offer 15 six-week self-management class series for Chronic Disease and Diabetes in English and Spanish (up from 8 class series last year) throughout the District to ensure monthly referral resource for providers.
- Expand collaboration with FRCs to offer cooking classes and prenatal education.

TAHOE FOREST HOSPITAL DISTRICT

MEMORADUM OF UNDERSTANDING

This MEMORADUM OF UNDERSTANDING ("MOU"), is effective as of the October 1, 2016, by and among **Tahoe Forest Hospital District**, a California local health care district (the "District"), **North Tahoe Family Resource Center ("NTHRC")**, a California non-profit corporation, and **Family Resource Center of Truckee ("FRCoT")**, a California non-profit public benefit corporation (each a "Grantee" and collectively "Grantees").

WHEREAS, the Board of Directors of the District has adopted a goal that there shall be no inequities in health status in the community served by the District on account of race or ethnicity;

WHEREAS, in furtherance of such goal, the District desires to make a grant to Grantees for purposes of: (i) improving the health of the Latino population in the community served by the District; and (ii) improving the cultural competency of the District by evaluating existing services, identifying gaps in the District's delivery of such services to the Latino population, and recommending improvements relative to the delivery of such services to the Latino population;

WHEREAS, each Grantee has the requisite resources and abilities to receive grant funding and use the same in a manner that will assist the achievement of the above;

NOW, THEREFORE, the District and Grantees agree as follows:

1. Grant. The District hereby makes a grant ("Grant") to Grantees in the total amount of **Ninety-Six Thousand One Dollars** ($96,001.00), for the purposes and subject to the terms and conditions hereof. The Grant is payable in the amounts of **Forty-Eight Thousand Three Hundred Sixty-Six Dollars** ($48,366.00) to FRCoT and **Forty-Eight Thousand Six Hundred Thirty-Five Dollars** ($47,635.00) to NRHRC, to be used by each Grantee for the purposes set forth below, as further detailed on **Exhibit A** hereto.

2. Annual Appropriation. Notwithstanding the foregoing, in the event payment of the Grant spans more than one fiscal year of the District, and the District's Board fails to appropriate sufficient moneys to fund the Grant in any subsequent year, the amount of the Grant is subject to reduction. In such event, the District shall provide prompt notice to each Grantee, specifying the amount of any such reduction, and detailing how the reduction shall be applied to the purposes set forth on **Exhibit A**.

   a) Reallocation. Notwithstanding the foregoing, Grantees may agree to reallocate the amount of the Grant between them, by providing written notice of amended activities/deliverables in collaboration with the District.

b) Allowable Line Item Shifts. Notwithstanding the foregoing, each Grantee may request shifting the expenditure of the Grant among the line items reflected on **Exhibit A** by notice to the District.

c) Purpose. A Grantee may use its share of the Grant for costs incurred in the following activities, but not in excess of the maximums set forth on **Exhibit A** (subject to such reallocations and shifts permitted by Section 1).

3. Management. Each Grantee may use Grant funds for the cost of its management personnel for time spent in administering Grant programs and Grant related activities. Reimbursement shall be at a Grantee's actual compensation costs for management personnel for actual time spent, assuming a forty-hour work week, inclusive of salary, benefits and payroll taxes.

4. Travel. Each Grantee may use Grant funds for travel costs incurred by its personnel or contractors in furtherance of Grant programs. Except for travel expenses otherwise approved by District in advance, reimbursable travel expense shall be limited to automobile mileage and taxi fares for travel within the community served by the District, but in no event including any cost of commuting between a person's home and a Grantee's place of business where such person principally works. Mileage shall be reimbursed at the *GSA (Government Services Administration)* rate.

5. Supplies. Each Grantee may use Grant funds for the actual costs of educational materials acquired in furtherance of Grant programs.

6. Rent. Each Grantee may use Grant funds for the proportional costs of office space associated with the Promotora program.

7. Work Plan. Within thirty (30) days of the Commencement Date, Grantees shall prepare and deliver to District a work plan, setting out in detail the programs to be developed and pursued by the promotoras. Such work plan shall be subject to District's approval, which shall not be unreasonably withheld. In the event District objects to an aspect of a proposed work plan, it shall promptly specify its objection by notice to Grantees, and the parties shall use reasonable efforts to achieve a mutually acceptable work plan as soon as practicable, *provided* that if the parties are unable to achieve a mutually acceptable work **plan** within sixty (60) days of the Commencement Date, District may terminate this MOU by notice to Grantees. Grantees together may propose changes to an approved work plan, subject to District's approval, *provided* that District's failure to object to a proposed change within thirty (30) days shall be deemed approval.

8. Term and Termination. The Grant provided hereby is expected to fund the programs contemplated hereby for the term of July 1, 2016 through June 30, 2017. Period may be extended with District's approval (the "Term"). Upon the breach of any representation, warranty, covenant or other provision hereof by a Grantee and the continuation of the same for thirty (30) days or more after District's notice to such Grantee, District may terminate this MOU as to such Grantee immediately upon notice, *provided* that if

District then reasonably concludes that it would be impractical to continue this MOU as to the other Grantee under such circumstances, it may also terminate this MOU as to the other Grantee upon not less than thirty (30) days' notice.

9. Grant Disbursement. District shall disburse the Grant payments to each Grantee in two installments of fifty percent (50%) of the total designated in **Section 1** of this MOU to each Grantee. The first installment to each Grantee will be disbursed within ten (10) days after Board approval. The second installment to each Grantee will be disbursed by December 31, 2016.

10. Progress Reports. Reports shall include a summary of activities performed that address the scope of work including: (i) the number of community encounters through program activities; (ii) dates of training of promotoras (if applicable); (iii) dates of promotion programs with attendance and (iv) recommendations for improving cultural competency of the District. The Grantee may include any progress notes and recommendations deemed necessary to explain the implementation or delays with any grant activities. The District may, by notice to a Grantee, provide further direction as to the form or content of a progress report. Grantees shall submit a progress report of grant activities and issues that affect grant progress and activities by January 31, 2017 (for the period of July I, 2016- December 31, 2016) and a final report by July 31, 2017 (for the period of January1, 2017- June 30, 2017).

11. Record Retention: Audit and Repayment. Each Grantee shall maintain, for a period not less than five (5) years after the end of the Term, books, records, documents and other evidence sufficient to reflect all costs of whatever nature claimed hereunder. District shall have the right, through its officers, employees and agents, to: (i) audit and make copies of all such books, records, documents and other evidence; (ii) to interview a Grantee's directors, officers and employees; and (iii) inspect a Grantee's work locations, all during the Grantee's normal work hours, upon not less than twenty-four (24) hours advance notice and for a period of not less than five (5) years after the end of the Term. If District determines in its reasonable discretion that any item of expense claimed by a Grantee that District has paid or reimbursed is not allowable hereunder, the Grantee promptly shall repay such item to District upon District's notice of the same.

12. Staff Subcontractors. The Grantees may obtain subcontractor services, as agreed to by the District in advance, to the extent that such services fulfill the specific activities outlined in this amended Grant and cannot be fulfilled by the Grantee. A Grantee shall promptly notify District whenever there is any change in the person serving as its Executive Director (or comparable position)

13. Grantee Representations and Covenants. Each Grantee represents, warrants and covenants, as of the date hereof and as of the date of each invoice presented hereunder, as follows:

    a. Organization. It is a duly organized and validly existing non-profit corporation, in good standing, under the laws of California or Nevada.

b. Exempt Status. It has obtained a determination from the Internal Revenue Service that it is an organization described in Section 50l(c)(3) of the Internal Revenue Code, and such determination remains in full force and effect.

c. Due Authorization. It has duly authorized its execution and delivery of this MOU, and the same constitutes its valid and binding obligation, enforceable in accordance with its terms.

d. No Conflict. Its execution, delivery and performance of this MOU does not, with or without the giving of notice, the lapse of time or otherwise or both, contravene or conflict with its organizational documents, any law or regulation to which it is subject or any agreement, order, permit or license to which it or a substantial part of its assets is subject.

e. No Consent. No consent, order, approval or authorization is required in connection with the execution and delivery of this MOU except as has already been obtained and remains in full force and effect.

f. Tax Returns. It has duly filed all federal, state and local tax returns that it is required to file and it has paid all taxes due and owing by it.

g. Good Title. It has good and marketable title to or a valid leasehold interest in all assets used and reasonably requisite to the conduct of its activities.

h. Compliance with Laws. It has conducted its activities in compliance in all material respects with all applicable laws, regulations, judgments, decrees, rulings and orders. It has all permits, certifications, licenses and other regulatory authorizations necessary for the conduct of its activities, and there is no claim, proceeding or controversy pending, or to the best of its knowledge threatened, challenging the status of or seeking sanctions under any such permit, certification, license or other regulatory authorization.

i. Driver's Licenses; Insurance. All Grantee employees or independent contractors who operate a motor vehicle on behalf of Grantee and in furtherance of its activities has a valid driver's license. Grantees possess automobile liability insurance in the amount of not less than $1,000,000 per occurrence for bodily injury and property damage combined. It shall provide a certificate of such insurance to District promptly upon District's request therefor.

j. Suspension or Exclusion; Fraud. No. employee or independent contractor who provides services to it has been suspended or excluded from participation in the Medicare or any Medicaid or other governmental health care program, or convicted of or had a civil judgment rendered against him or her for commission of sex-related crimes, drug-related crimes, fraud, embezzlement, theft forgery, bribery, making false statements or receiving stolen property.

k. Ineligible Aliens. None of its employees is an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act.

i. Politicking and Lobbying. It does not engage in any activities in support of or in opposition to any candidate for public office. It has not used any Grant proceeds to support or oppose any legislation, ordinance, referendum or ballot initiative.

14. Indemnification. Each Grantee shall indemnify District from and against any and all liabilities, claims, causes of action, losses, damages, expenses or costs incurred by or on behalf of District or its directors, managers, officers, employees, owners or agents relating to or arising, directly or indirectly, from any breach by such Grantee of any representation or warranty made by it hereunder or any covenant or obligation to be observed or performed by it hereunder. In the event both Grantees bear an indemnification obligation hereunder relative to any particular liability, claim, cause of action, loss, damage, expense or cost, both Grantees shall be jointly and severally obligated to indemnify District.

a. District shall give prompt written notice to a Grantee of any claim hereunder, but the failure to so notify the Grantee will not relieve the Grantee of any liability it may have hereunder except to the extent such liability was caused by such failure. In any claim or action covered by the foregoing indemnity obligation, each Grantee may, at its sole option, elect to assume the defense thereof with counsel reasonably satisfactory to it, and District shall cooperate fully with the Grantee in defense of such claim or action. In the event that the Grantee assumes the defense thereof, the Grantee shall not be liable to District hereunder for any attorney and investigatory fees, costs and expenses subsequently incurred by District in the defense thereof; *provided,* however, that District shall have the right to employ separate counsel acceptable to the it and to participate in the defense of any such claim or action; *provided* further, that the Grantee shall bear the reasonable fees, costs and expenses of such separate counsel (and shall pay such fees, costs and expenses monthly) if District's counsel shall have reasonably concluded that there may be legal defenses available to District that are different from or additional to those available to the Grantee or that the use of counsel chosen by the Grantee to represent District would present such counsel with a commercially unreasonable conflict of interest. In the event that the Grantee fails to assume the defense of such claim or action within fourteen (14) days after notice from District, or assumes the defense subject to a reservation of rights, the Grantee shall reimburse District Party on a monthly basis for any legal or other similar expenses reasonably incurred by District in connection with investigating and defending against such claim or action (including the fees, costs and expenses of counsel retained by District). The Grantee shall not be liable to indemnify District for any payment or settlement of any claim or action effected without the prior written consent of the Grantee, which consent shall not be unreasonably withheld or delayed. In the event the Grantee desires to settle any claim or action, the Grantee may effectuate same in its reasonable discretion. This Section

I0 shall survive the consummation and termination of this MOU.

15. Mediation, Arbitration and Costs.

a. Mediation. If any dispute, controversy or claim arises out of or relates to this MOU, or the breach thereof, the parties shall first use their good faith efforts to resolve the dispute as follows. Any party may notify the other parties in writing that a dispute exists, and within twenty (20) days following the date of such notice, the representatives of such party shall meet to discuss the dispute. If they are unable to resolve the dispute within ten (10) days following their initial meeting, they shall attempt in good faith to agree to a single person to mediate such dispute, on a non-binding basis, and/or shall attempt in good faith to agree to submit the matter to JAMS/Endispute ("JAMS") for non-binding mediation pursuant to the rules of JAMS. If the parties cannot so agree, or if such mediation is unsuccessful, the matter shall be arbitrated as provided below.

b. Arbitration. In any dispute between the Parties arising out of this Agreement which would otherwise be resolvable in a court of competent jurisdiction, the Parties shall first try to resolve the dispute through direct discussions and negotiation. If such are unsuccessful, the aggrieved Party involved may commence litigation in the Superior Court of the State of California, in and for the county of (county name) (the "Court") for the purpose of resolving the dispute. The prevailing Party's compensation shall include reasonable legal costs associated with these processes and actions. The Parties hereby agree and consent that the resolution of the dispute by the Court shall be by way of a reference procedure as specified under California Code of Civil Procedure Section 638 (or any successor statute or statutes) and all rules of court relating thereto, and if such aggrieved Party does not file the required motion, the other Party may do so, and if neither Party files such motion, then the Court shall appoint a referee on its own motion as allowed under California Code of Civil Procedure Section 639 (or any successor statute or statutes). At the hearing on the motion, the Court shall appoint a referee (the "Referee") to hear all aspects of the matter in dispute, including without limitation, substantive issues and discovery disputes, and such reference procedure (regardless of how a Referee may be appointed) shall be deemed "consensual" in nature and all Parties hereto agree thereto. The reference procedure set forth in this Section is the exclusive remedy for any Party hereto to resolve disputes arising under the within Agreement if they are unable to resolve them amicably among themselves, and such shall be in lieu or arbitration at any point in the resolution proceedings.

16. General Provisions

a. Law. This MOU shall be construed and interpreted under and pursuant to the laws of the State of California.

b. Entire MOU. This MOU, the Exhibits hereto, and other related documents constitute the entire agreement of the parties with respect to the subject matter hereof and supersede all prior written or oral, and all contemporaneous oral, agreements, understandings and negotiations between the parties with respect to

the subject matter hereof

c. Severability. Except as provided herein, any portion or provision of this MOU which is deemed to be invalid, illegal or unenforceable shall be ineffective to the extent of such invalidity, illegality or unenforceability, without affecting in any way the remaining portions or provisions hereof.

d. Waiver of Compliance. The failure of any party to observe or perform any obligation, covenant, agreement or condition in this MOU on its part to be observed or performed may only be waived in writing by the other parties to this MOU, but such waiver or failure to insist upon strict compliance with such obligation, covenant, agreement or condition shall not operate as a waiver of, or estoppel with respect to, any subsequent or other failure.

e. Amendment. This MOU may not be amended without the written consent of all of the parties hereto.

f. Assignment. Except as specifically provided herein, neither Grantee may assign this MOU or any interest herein without the prior written consent of District.

g. Notices. All notices, requests, demands, and other communications hereunder shall be in writing and shall be deemed to have been given when delivered personally, when deposited with an overnight courier or in the United States mail, certified, and with proper postage prepaid, addressed as follows, or when sent by fax or email, addressed as follows:

If to District:

Tahoe Forest Hospital District:
10121 Pine Avenue
Truckee, California 96161
Attention: Karen Gancitano
Chief Nursing Officer
Telephone: (530) 582-7425
Email: kgancitano@tfhd.com

If to North Tahoe Family Resource Center:

Amy Kelley
Executive Director
8321 Steelhead Ave.
Kings Beach, CA 96143
Telephone: (530) 546-0952

Email: amykelley.ntfrc@gmail.com

If to Family Resource Center of Truckee:

Teresa Crimmens
Executive Director
11695 Donner Pass Rd Truckee, CA 96161
Telephone: (530) 587-2513
Email: teresa@truckeefrc.org

Subject to the preceding sentence, this MOU and all of the provisions hereof shall be binding upon, shall inure to the benefit of, and shall be enforceable by the parties hereto and their respective successors and permitted assigns.

If such notice, demand or other communication is served personally, or sent by fax or email, service shall be deemed made at the time of personal service or transmission, *provided there* is evidence of receipt. If such notice, demand or other communication is given by overnight courier, service shall be conclusively deemed given two (2) business days after the deposit thereof with the overnight courier. If such notice, demand or other communication is given by mail, service shall be conclusively deemed given three (3) business days after the deposit thereof in the United States mail addressed to the party to whom such notice, demand or other communication is to be given, as hereinabove set forth. Any party hereto may change their address for the purpose of receiving notices, demands or other communications provided herein by giving a written notice in the manner stated above to the other party or parties stating such change of address.

a. Execution in Counter parts. This MOU, and any amendment hereto, may be executed by the parties in separate counterparts, and provided that each party shall have originally executed at least one such counterpart, each such executed counterpart, and any photocopies or facsimile copies thereof, shall be deemed an original, but all such counterparts and any such photocopies and facsimile copies, together shall constitute one and the same instrument, even though all of the parties have not originally executed the same counterparts..

IN WITNESS WHEREOF, the parties have executed this Grant MOU as of the day and year first written above.

Amended Signatures:

TAHOE FOREST HOSPITAL DISTRICT-WELLNESS NEIGHBORHOOD

Karen Gancitano, Chief Nursing Officer *Date*

NORTH TAHOE FAMILY RESOURCE CENTER

Amy Kelley, Executive Director *Date*

FAMILY RESOURCE CENTER

Teresa Crimmens, Executive Director *Date*

Exhibit A
Budget and Scope of Work

Total FRCoT Budget: $ 48,366.00
Total NTFRC Budget: $ 47,635.00
Total Contract Amount: Contract Period: $ 96,001.00

Tahoe Forest Hospital District: Ethnic Disparities Grant

Family Resource Center of Truckee (FRCoT)
Budget and Scope of Work
July 1, 2016, ("Commencement Date") – June 30, 2017

Activity	Detail	Budgeted line items
Prevention & Intervention: Track 1 **Chronic Disease Self-Management and Diabetes Self- Management** Program Goal: to engage targeted community members with chronic disease in comprehensive workshops (CDSMP and DSMP) providing them with skills and knowledge to manage their disease and improve their health outcomes	(3 Workshops @ $1760/workshop = $5280) 1. Trained Promotoras will provide 3 six-week workshops with 2 guest lectures each for community members @ $1760/workshop (2 leaders X 44 hours / workshop x 3 workshops x $20/hr) 2. CDSMP Leader training for 6 promotoras (2.5 hrs x 6 weeks x $20/hr x 6 promotoras) 3. 1 Promotora will Partner with Reyna to lead 1 DSMP in Spanish (42 hrs x $20/hr) 4. Childcare (3 workshops x 8 classes/workshop x 3 hrs x $12/hr)	*1. $5,280* *2. $1,800* *3. $ 840* *4. $ 864*
Quality Circles: Track 2 Program Goal: To provide education, continuous quality improvement, and enhanced communication for all CDSMP and DSMP leaders.	5. Monthly 1 hr conference call with Q-TAC, Nevada (1 hr x 6 promotoras x $20/hr x 12 months) 6. Quarterly Leader meetings in Reno at the Sanford Center on Aging (4 hrs x 6 promotoras x $20/hr x 4 quarters)	*5. $1,440* *6. $1,920*
Care Navigation: Track 3 Program Goal: to support community members in identifying a medical home,	7. 2 Family Advocates from the Family Resource Center of Truckee will provide 165 hours of care navigation to 40 community members per year. (165 hours total @ $24/hour)	*7. $3,960* *8. $4,375*

engaging in preventative health care and assisting them in accessing follow up specialty care including dental health services	8. Program Manager will provide oversite, resources and data tracking to support this process. (125 hours @ $35/hour)	
Program Manager	9. Self-Management Program oversight (10 hrs/workshop x 3 workshops x $35/hr) 10. Evaluation Planning and oversight of community education (3 hrs/wk x 50 weeks x $35/hr) 11. Translation (2 hrs/guest class x 2 classes x 3 workshops x $35/hr) 12. Leader Training for CDSMP (40 hrs/session x $35/hr)	*9. $1,050* *10. $5,250* *11. $ 420* *12. $1,400*
Executive Oversight	13. Direction of grant deliverables and financial oversight provided by FRCoT Executive Director	*13. $ 5,000*
Program Support	14. Supplies, materials, travel, etc.	*14. $ 2,330*
Client Behavioral Health Services Program Goal: to provide counseling support to underinsured and uninsured community members who present with at risk behavior	15. Behavioral health services for emergency client needs: 38 hours of direct mental health services will be provided to community members in need by licensed MFT or MCSW. Rate of reimbursement is $80.00/hour 16. Referrals will be supported by care coordination provided by Family Advocates.	*15. $ 3,040* *16. Included in track II line item for Family Advocates*
Training/Development	17. Visione y Compromiso, Mental Health First Aid, etc.	*17. $ 5,000*
Indirect Costs	10% indirect rate	*$ 4,397*
TOTAL FRCoT		***$48,366.00***

Tahoe Forest Hospital District: Ethnic Disparities Grant

North Tahoe Family Resource Center (NTFRC)
Budget and Scope of Work
July 1, 2016 – June 30, 2017

Activity	Detail	Budgeted line items
Prevention & Intervention: Track 1 **Chronic Disease Self-Management and Diabetes Self- Management** Program Goal: to engage targeted community members with chronic disease in comprehensive workshops (CDSMP and DSMP) providing them with skills and knowledge to manage their disease and improve their health outcomes	CDSM and DSMP: (3 Workshops @ $1760/workshop = $5280) 1. Trained Promotoras will provide 3 six-week workshops with 2 guest lectures each for community members @ $1760/workshop (2 leaders X 44 hours / workshop x 3 workshops x $20/hr) 2. CDSMP Leader training for 6 promotoras (2.5 hrs x 6 weeks x $20/hr x 6 promotoras) 3. 1 Promotora will Partner with Reyna to lead 1 DSMP in Spanish (42 hrs x $20/hr) 4. Childcare (3 workshops x 8 classes/workshop x 3 hrs x $16/hr) Cooking Matters: 5. Childcare 2 workshops x 6 classes/workshop x 3.5 hrs x $16/hr) 6. $10 incentive for participation (12 /workshops x 2 workshops x $10) 7. Outreach (5 hours/ workshop x 2 workshops x $16/hr)	*1. $ 5,280* *2. $ 1,800* *3. $ 840* *4. $ 1,152* *5. $ 672* *6. $ 240* *7. $ 160*
Prevention and Intervention	Prenatal Education Series (12 hours/series x 2 series):	

Track 1 **Prenatal Education**	8. Translation (12 hr x 2 series x $20/hr) 9. Childcare (18 hours (includes set up and clean up) x 2 series x $16/hr) 10. Outreach (6 hours/series x 2 series x $16/hr)	*8. $ 480* *9. $ 576* *10. $ 192*
Quality Circles: Track 2 Program Goal: To provide education, continuous quality improvement, and enhanced communication for all CDSMP and DSMP leaders.	11. Monthly 1 hr conference call with Q-TAC, Nevada (1 hr x 6 promotoras x $20/hr x 12 months) 12. Quarterly Leader meetings in Reno at the Sanford Center on Aging (4 hrs x 6 promotoras x $20/hr x 4 quarters)	*11. $ 1,440* *12. $ 1,920*
Care Navigation: Track 3 Program Goal: to support community members in identifying a medical home, engaging in preventative health care and assisting them in accessing follow up specialty care including dental health services	13. 2 Family Advocates from the Family Resource Center of Truckee will provide 165 hours of care navigation to 40 community members per year. (165 hours total @ $24/hour) 14. Program Manager will provide oversite, resources and data tracking to support this process. (125 hours @ $35/hour)	*13. $ 3,960* *14. $ 4,375*
Program Manager	15. Self-Management Program oversight (10 hrs/workshop x 3 workshops x $35/hr) 16. Evaluation Planning and oversight of community education (3 hrs/wk x 50 weeks x $35/hr) 17. Translation (2 hrs/guest class x 2 classes x 3 workshops x $35/hr) 18. Leader Training for CDSMP (40 hrs/session x $35/hr)	*15. $ 1,050* *16. $ 5,250* *17. $ 420* *18. $ 1,400*
Executive Oversight	19. Direction of grant deliverables and financial oversight provided by NTFRC Executive Director	*19. $ 5,000*
Program Support	20. Supplies, materials, travel, etc.	*20. $ 2,330*
Client Behavioral Health Services Program Goal: to provide counseling support to underinsured and uninsured	21. Behavioral health services for emergency client needs: 38 hours of direct mental health services will be provided to community members in need by licensed MFT or MCSW. Rate of reimbursement is $80.00/hour	*21. $ 3,040* *22. Included*

community members who present with at risk behavior	22. Referrals will be supported by care coordination provided by Family Advocates.	*in track II line item for Family Advocates*
Training/Development	23. Visione y Compromiso, Mental Health First Aid, etc.	*23. $ 5,000*
Indirect Costs	10% indirect rate	*$ 4,658*
Rollover	2015-2016 unspent funds	***< $,3600>***
TOTAL NTFRC		***$47,635***

COMMUNITY BENEFIT COMMITTEE
AGENDA

Thursday, September 8, 2016 at 10:00 a.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Karen Sessler, M.D., Chair; Charles Zipkin, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 06/14/2016 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Memorandum of Understanding Grant Award..... ATTACHMENT
Committee will review a Memorandum of Understanding Grant Award for North Tahoe Family Resource Center and Family Resource Center of Truckee.

6.2. Wellness Neighborhood Update..... ATTACHMENT
Committee will review the goals, dashboard and brochure for the Wellness Neighborhood.

6.3. Care Coordination Update ..... ATTACHMENT
Committee will review the blue:life, Healthy Hearts, Multi-Specialty Clinics implementation and navigation components of Care Coordination.

6.4. PRIME Program Update..... ATTACHMENT
Committee will receive an update on the District's PRIME program.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. AGENDA INPUT FOR NEXT COMMITTEE MEETING

9. NEXT MEETING DATE

10. ADJOURN

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

GOVERNANCE COMMITTEE AGENDA

Wednesday, September 14, 2016 at 8:00 a.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
John Mohun, Chair; Greg Jellinek, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. CLOSED SESSION
5.1. Approval of Closed Session Minutes: 07/20/2016

6. APPROVAL OF MINUTES OF: 07/20/2016

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
7.1. Contracts
New, amended, and auto renewed contracts are submitted to the Governance Committee for review and consideration for recommendation of approval by the Board of Directors.
- **7.1.1. Robert Mancuso, M.D. – Professional Services Agreement**..... ATTACHMENT
- **7.1.2. David Kitts, M.D. – Professional Services Agreement** ..... ATTACHMENT
- **7.1.3. Ephraim Dickinson, M.D. – Professional Services Agreement** ..... ATTACHMENT
- **7.1.4. Kevin Cahill, M.D. – Professional Services Agreement**..... ATTACHMENT

7.2. Policies
- **7.2.1. Professional Courtesy Policy** ..... ATTACHMENT

Committee will review revisions for the TFHD Professional Courtesy Policy.

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

9. NEXT MEETING DATE
The next Governance Committee meeting is scheduled for October 19, 2016 at 8:00 a.m.

10. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 9/13/16

We are happy to report that we have a new permanent Executive Director of Physician Services. Scott Baker, who will join us on or around 10/10/16, is coming to us with great physician medical group experience running large independent multi-specialty medical groups in the Seattle area. His presence will really assist in our journey for a total makeover of physician services, one of our Critical Strategies for strong alignment and improved efficiency across all team members in the healthcare system. We are appreciative of Tom Wright's efforts as Interim Executive Director of Physician Services.

Our team is working on obtaining the State of California approvals for our Management Services Organization named Tahoe Forest Health Care Services Inc. As more details arise, we'll bring back more specifics for your consideration. We are still targeting a January 1, 2017 go live date on this important entity which will employ those non physician personnel who support our physician team members. Our HR team is actively working on payroll and benefit services for this new entity and also with for our "Friendly PC" as noted below.

We are also beginning work with legal counsel to start filings with the State of California for a "Friendly Professional Corporation" (PC) after the board's approval last month to begin work on this critical resource to recruit and retain physicians. This project is just beginning.

We are gathering data as requested from our Rural Health Clinic (RHCs) expert so that he can determine if, where and how many RHCs we should have here and in Incline Village to serve as a critical invisible business backdrop for as many of our physician specialties as possible. Again, our goal on this topic, which is a critical component of the makeover of Physician Services, is to have this properly incorporated into all of our master planning work which is another of my six critical strategies.

Our master planning work continues and is quite complex as healthcare rules in the State of California have changed in the last 15 years requiring many non-hospital healthcare services to now be in a certain level of seismic level of construction. Each improvement or change we consider also must take into consideration State of California seismic requirements which may exist for services provided outside of hospital walls. We have a long list of variables to consider so that we properly place all team members or groups in optimal space for function, growth, and optimal business and quality efficiency. We are targeting having a Master Plan we can begin to execute by January 1, 2017.

We have fully commenced our Care Coordination Strategy and are still working on its companion critical strategy called Patient Navigation. A lot of fundamentals are being worked

before we start it in one service line and then expand it across the hospital. We are still planning on having Patient Navigation up and running by the end of this calendar year.

We are strongly moving forward in our “Just Do It” critical strategy which is to improve Quality, Patient Satisfaction, Compliance and Hospital Finances. All areas are showing improvement.

Our team lead by our CIO is also moving rapidly on our critical strategy to implement a new Electronic Health Record and respective business companion software across the system. Our CIO is covering more on this topic during the Board Meeting.

The last, but not least, of our 6 critical strategies is to connect with our community on a regular and growing basis. This is an ongoing objective and we have many new types of community outreach that are underway now.

We are continuing our new and regular communications to all households in the District and also a monthly communication to our medical staff, and our directors and managers in the hospital as well.

We will be holding two Fact or Fiction Healthcare 101 community discussions this month. The first forum was held earlier in the month and had good attendance. We have another that will be held on the evening of September 26. We will schedule another community discussion in October as well.

We are in the fastest and most complex change era in healthcare versus the last 100 years so it is important to share that during the last three years, hospital ownership of physician practices has grown 86% across America. This is a profound change that will not slow down for some time.

Further, as an additional example of significant change, the “Stark Law passed by Congress first in 1989 and then refreshed a bit in 1995 is now being declared by many healthcare experts and even Congress itself to be way out of date and to actually be an impediment to the journey to leave the “fee for service” medicine world and to move forward to “payment for value” medicine. This 27 year old law in many ways is trying to kill healthcare reform that is sought by so many today. We will watch and contribute as necessary as discussions on this law arise.

I have attached an important article from Becker’s Healthcare News showing 77 rural hospitals across the US who have closed since 2010. Our goal and that of our community is to be among the nimble and very healthy health systems for many years ahead even though the challenges will be significant.

We continue to be vigilant and actively monitor all state and federal laws that can impact healthcare either positively or negatively.

A state-by-state breakdown of 77 rural hospital closures

Written by Ayla Ellison (Twitter | Google+) | August 23, 2016 | Print | Email

Of the 25 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South, according to research from the North Carolina Rural Health Research Program.

Ten hospitals in Texas have closed since 2010, the most of any state. Tennessee has seen the second-most closures, with eight hospitals closing since 2010. In third place is Georgia with six closures followed by Alabama, which has seen five hospitals close over the past six years.

Listed below are the 77 rural hospitals that have closed since 2010, as tracked by the NCRHRP. For the purposes of its analysis, the NCRHRP defined a hospital closure as the cessation in the provision of inpatient services. Although all of the facilities listed below no longer provide inpatient care, many of them still offer other services, including outpatient care, imaging, emergency care, urgent care, primary care or skilled nursing and rehabilitation services

Alabama
Chilton Medical Center (Clanton)
Elba (Ala.) General Hospital
Florala (Ala.) Memorial Hospital
Randolph Medical Center (Roanoke)
South West Alabama Medical Center (Thomasville)

Arizona
Cochise Regional Hospital (Douglas)
Florence (Ariz.) Community Healthcare
Hualapai Mountain Medical Center (Kingman)

California
Colusa (Calif.) Regional Medical Center
Corcoran (Calif.) District Hospital
Kingsburg (Calif.) Medical Center

Georgia
Calhoun Memorial Hospital (Arlington)
Charlton Memorial Hospital (Folkston)
Hart County Hospital (Hartwell)
Lower Oconee Community Hospital (Glenwood)

North Georgia Medical Enter (Ellijay)
Stewart-Webster Hospital (Richland)

Illinois
St. Mary's Hospital (Streator)

Kansas
Central Kansas Medical Center (Great Bend)
Mercy Hospital Independence (Kan.)

Kentucky
New Horizons Medical Center (Owenton)
Nicholas County Hospital (Carlisle)
Parkway Regional Hospital (Fulton)
Westlake Regional Hospital (Columbia)

Maine
Parkview Adventist Medical Center (Brunswick)
Southern Maine Health Care – Sanford Medical Center
St. Andrews Hospital (Boothbay Harbor)

Massachusetts
North Adams (Mass.) Regional Hospital

Michigan
Cheboygan (Mich.) Memorial Hospital

Minnesota
Albany (Minn.) Area Hospital
Lakeside Medical Center (Pine City)

Mississippi
Kilmichael (Miss.) Hospital
Merit Health Natchez (Miss.) – Community Campus
Patient's Choice Medical Center of Humphreys County (Belzoni)
Pioneer Community Hospital of Newton (Miss.)

Missouri
Parkland Health Center – Weber Road (Farmington)
Sac-Osage Hospital (Osceola)
SoutheastHEALTH Center of Reynolds County (Ellington)

Nebraska
Tilden (Neb.) Community Hospital

Nevada
Nye Regional Medical Center (Tonopah)

North Carolina
Blowing Rock (N.C.) Hospital
Franklin Regional Medical Center (Louisburg)
Vidant Pungo Hospital (Belhaven)
Yadkin Valley Community Hospital (Yadkinville)

Ohio
Doctors Hospital of Nelsonville (Ohio)
Physicians Choice Hospital-Fremont (Ohio)

Oklahoma
Epic Medical Center (Eufaula)
Memorial Hospital & Physician Group (Frederick)
Muskogee (Okla.) Community Hospital
Sayre (Okla.) Memorial Hospital

Pennsylvania
Mid-Valley Hospital (Peckville)
Saint Catherine Medical Center Fountain Springs (Ashland)

South Carolina
Bamberg (S.C.) County Memorial Hospital
Marlboro Park Hospital (Bennettsville)
Southern Palmetto Hospital (Barnwell)
Williamsburg Regional Hospital (Kingstree)

South Dakota
Holy Infant Hospital (Hoven)

Tennessee
Gibson General Hospital (Trenton)
Haywood Park Community Hospital (Brownsville)
Humboldt (Tenn.) General Hospital
McNairy Regional Hospital(Selmer)
Parkridge West Hospital (Jasper)
Pioneer Community Hospital of Scott (Oneida)
Starr Regional Medical Center-Etowah (Tenn.)
United Regional Medical Center (Manchester)

Texas
Bowie (Texas) Memorial
East Texas Medical Center-Clarksville
East Texas Medical Center-Gilmer
East Texas Medical Center-Mount Vernon
Good Shepherd Medical Center (Linden)
Hunt Regional Hospital of Commerce (Texas)
Lake Whitney Medical Center (Whitney)
Renaissance Hospital Terrell (Texas)
Shelby Regional Medical Center (Center)
Wise Regional Health System-Bridgeport (Texas)

Virginia
Lee Regional Medical Center (Pennington Gap)

Wisconsin
Franciscan Skemp Medical Center (Arcadia)

More information on the rural hospitals that have closed since 2010 can be accessed here.

More articles on healthcare finance:

Jake Dorst **DATE:** 8/15/2016

STRATEGIC INITIATIVE 4.0

Epic Mercy /Renown

- Continuing to refine our proposals and negotiations.

ChartLink Patch Issue

- End to End testing scheduled for next week. Have all patches ready in Test.
- Need to move to live by 9/20/16.

CancerLinQ

- Technical call completed.
- CancerLinQ will allow TFHD to gain valuable insights and uncover trends from the vast CancerLinQ population that can improve the quality of care provided to each of our patients.

Parlance Automated Attendant

- New automated phone attendant using voice recognition technology.
- This software will analyze caller behavior and delivering innovative solutions to organizations for more than two decades. With Parlance Operator Assistant, callers just speak and behave naturally, like they would with a live operator.
- We are testing internally and will move to the public facing phone number in a few weeks.

Barton Oncology Clinic

- Setting up two Barton IT staff with access to Varian cancer software test environment via remote access.

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Karen Baffone, RN, MS
Chief Nursing Officer

DATE: September 2016

Strategy Three: Creating and implementing a New Master Plan that will have to reach out several years into the future to assure we have the appropriate clinical space for physicians, hospital activities and critical parking for all.

The women and family department continue to ready themselves for the opening of the new wing. Nursing and all Post Acute/Population Health Management departments are working with the administrative staff to determine space needs that will best assist our patients in accessing care within the District.

Strategy Four: Developing and implementing a comprehensive Care Coordination Plan coupled with Patient Navigation for all patients that touch our healthcare system.

Chronic Care Coordination: TFHD was recognized by the National Rural Health ACO for their work in Care Coordination stating that we are "well ahead" of other members within the ACO. The Care Coordination team has been working with the MSC offices to grow referrals for those patients with two or more chronic conditions.

The Care Coordination and PRIME program has also been recognized by CMS through the White House for our work with the substance abuse stating:

> "White House's Office of National Drug Control Policy (ONDCP) highlighted Tahoe-Truckee's FWDD for their innovative opioid prevention initiative: In California, the Tahoe-Truckee Future Without Drug Dependence is working towards reducing access to prescription pain medications. They are focusing on safe disposal programs, and also educating prescribers on proper prescribing practices. Currently, the coalition is working with the Tahoe Forest Health System and the Placer and Nevada County Safe Opioid Steering Committee to institutionalize new best prescribing and chronic pain management practices."

Orthopedic Navigation Process: On September 5, 2016 TFHD did a soft launch of our navigation process with the orthopedic practice. We will work with the office to streamline surgical candidate to expedite timely surgeries and decrease wait times as well as work with patients to ensure that they stay within the system and prevent outmigration related to wait times and other referrals outside of the District.

Strategy Five: “Just Do It” Continue to show measureable annual improvements in Quality, and Patient Satisfaction.

Patient Satisfaction – The most recent inpatient patient satisfaction report has been published has TFHD regaining its “5” star status. We will continue to work to streamline the discharge process and will continue to look to our community to assist us in providing services that they identify for us to better communicate and teach prior to the discharge process.

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Judith B. Newland **DATE: September, 2016**

Construction projects continue on schedule.

1. At Incline Village Community Hospital (IVCH), the siding is moving forward on schedule with a completion date in October. Above is a picture of the new color, rock work and storefront/entry changes that are occurring. IVCH is hosting an open house and chamber mixer on October 13 to celebrate 20 years as being a member of the Tahoe Forest Health System.
2. At Tahoe Forest Hospital, the Measure C project for Dietary and Women & Family Center are nearing completion. The open house for the Joseph Family Women and Newborn care is scheduled for October 6th. The Helipad and parking near the area has been resurfaced. Opening of the Helipad will occur once OSHPD has approved the South Building.

The California Special Districts Association (CSDA) and the Association of California Healthcare Districts (ACHD) annually organizes a tour for key legislative staff members (See attached roster) to promote good local governance at all levels. This year they organized a tour of "diverse special districts" and Tahoe Forest Hospital District (TFHD) was selected representing Healthcare Districts. The goal of CSDA and ACHD is to provide greater understanding of how special districts conduct their business and strive to:

- Effectively and efficiently deliver essential local services;
- Promote accessible and responsive government;
- Serve unique regions based on local needs;
- Build, operate, and sustain critical infrastructure and protect public health and safety.

TFHD hosted 23 attendees for lunch welcomed by Board President Dr. Chuck Zipkin. Presentations of a variety of topical issues and information by Harry Weis, Crystal Betts, Judy Newland, Jake Dorst, Ted Owens and Rick McConn. Issues covered were TFHD history, composition, innovation, service levels, financial operations, property tax contribution and position, populations served, Measure C projects and governance. This was followed by a campus tour culminating with a presentation from Maria Martin at the MOB where she covered TFHD efforts in community health and collaborations with FRC's and in particular the Tahoe Truckee Unified School District (TTUSD). Strategically, this was an excellent opportunity to present ourselves as available resources for these staff members during the new legislative session. We are picking up information that indicates there will be legislation aimed at special districts, healthcare districts in particular. Comments indicated that we were well received and the time with TFHD was well spent.

In support of obtaining a high employee compliance for flu immunization, Employee Health will now be offering flu immunizations 5 days per week in the hospital front lobby from October 3 – October 31. Flu Immunizations will be offered Monday, Wednesday, and Friday from 6:00am – 8:30am and Tuesday and Thursday from 6:00pm to 8:00pm. The goal is to improve access to the flu vaccine for all employees.

This past year Environmental Services Department (EVS) implemented a new Quality Assurance Program. The improvement in quality cleaning performance has increased Cleanliness of Hospital Environment patient satisfaction scores to 94% satisfaction. The U.S. and California averages are less than 75%. The environmental services staff have also been provided scripting for customer interaction that has contributed to the increase in satisfaction scores. A big thank you to the EVS staff for their ongoing dedication and commitment to the patients we serve.

Tahoe Forest Hospital District

Board of Directors Meeting Evaluation Form

Date: _____

		Exceed Expectations		Meets Expectations		Below Expectations
1	Overall, the meeting agenda is clear and includes appropriate topics for Board consideration	5	4	3	2	1
2	The consent agenda includes appropriate topics and worked well	5	4	3	2	1
3	The Board packet & handout materials were sufficiently clear and at a 'governance level'	5	4	3	2	1
4	Discussions were on target	5	4	3	2	1
5	Board members were prepared and involved	5	4	3	2	1
6	The education was relevant and helpful	5	4	3	2	1
7	Board focused on issues of strategy and policy	5	4	3	2	1
8	Objectives for meeting were accomplished	5	4	3	2	1
9	Meeting ran on time	5	4	3	2	1

Please provide further feedback here: